Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMISER 1:45 AM C. Maude Cahill 24 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Lanham Prince Georges 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🛛 F Hours Jan. 9, 1917 Months 579-14-8233 Director 92 Washington, D.C Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Mitchellville 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? by Funeral 10450 Lottsford Road #101 20721 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Secretary Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry O. Cutting Kate Posey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code)
1064 Tall Trees Court
GarnetValley, PA 1960 Susan C. Davies/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
George Cown University
Medical Center Dec. 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 X Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 Sle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 1 ☐ Yes 2 ♥ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

CHRONIC OBSTRYCTIVE PULMONARY DISEASE 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 2 D No illed in by the f Accident
Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. tem 23a) (Type, Print) KE KEWAY, SUITE , Day, Y 32. Registrar's Si State 2010 Registrar

			For Amend Item 2				ndelible Inl artment of 1 difficate of 1				gible.	1.2002
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				tillcate of L	Jean	2. Date of Dea	Aug W	Year	3. Time of Death
	Medic	cal		ay			Lab Other Towns	a Leasting of Dooth	DECEMI		200	
٠	Examir	ier	4a. Facility Name (if not institution, give str BAUTWORE WASH)		EDIC.	M. 16		r Location of Death stEN BU		4c. Count		E AKUNDEL
	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. lasi		If Under 1 Year Months Days		8. Date of Birt (Month, Ba June 20	h 5 ^Y 1 960	9. Birt Per	hplace (State or Foreign untry) insylvania
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru	ndel		Town or Lor adena	cation		,			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 7865 Red Lion Way				10f. Zip Code	21122		10g. Citizen of USA		untry?
980	s filed within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ck, White	rican Indian, e, etc. nite
Maryland 21215-0036	in 72 hour e. nan "natu Medical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ation completed) College (1-4 or 5		(Give :	dent's Usual Occup kind of work done (O NOT use retired)	during most of wor	king	16b. Kind of E		Industry
7	iled within Il Hygiene. Other thai	Be C	12	2			Firefigh					er County
ylánd	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To B	17. Father's Name (First, Middle, Last) Charles Day					18. Mother's Nan Audrey	` ' - '	Maiden Surnam amer	ne)	
Mar	d 2 should be alth and Men 1 27 is marke er traumatic		19a. Informant's Name/Relationship (Type Wendy L. Day (Wi	.fe)			ng Address (Street Red Lior					
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition 1 ☐ Burial 2 🏖 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cer	netery, crer	osition (Name of matory or other place Cremator	: 40/	Date 23/09	20c. Location Glen Br	-	
Balt	permit. Pag Departmen Important: any injury once.		21. Signature of Fineral Service Licensee			M B 2	2. Name and Addre cCully-Po O4Mountai	ss of Facility Olyniak F In Road,	uneral H Pasadena	Home P.	A. land	21122
	Physician/		23a. Pert 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition			Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner	1	resulting in death) Sequentially list conditions, b	Due to (or as								
_	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as								
09	ath certificate be executed attending physician and for use as the burial-transit	क्र	resulting in death) Last	Due to (or as	a conseque	nce or):						
. Box 68760	Attending Physician: The law requires that the death certificate £ scroeadh. scror: After this certificate has been signed by the attending physis y the funeral director, page 2 should be detached for use as the £	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су			ate of de	livery Day Year
ls, P.O.	v requires that the second point of the p	þ	Part II. Other significant conditions conf	ributing to death b	out not resul	ting in the u	underlying cause gi	ven in Part I.				the cause of death?
Division of Vital Records,	sician: The law req certificate has bee irector, page 2 shou	Completed							24a. Was autop perfo		prior to death?	topsy findings available completion of cause of
a	ian: T irtifica stor, p	Be C	25. Was case referred to medical examiner?				26. P	lace of Death (Che		2 23 110		
Ξ	hysic his ce al direc	은	1 Yes 2 No				nt 3 🗆 DOA Oth	4 ☐ Nursing F	lome 5 Resid			eify)
on of	ending P sath. or: After t he funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Day		8b. Time of injury	worl	y at k? Yes 2 No	28d. Describe h	now injury occur	rred	
5	cal or Attu s after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulg		ne, farm, str	eet, factory, office		28f. Location (S City or Tov		ber or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nurse	r: On the basis of e	xamination a	and/or inves	tigation, in my opini	on, death occurred	at the time, date a	and place, and d	ue to the	cause(s) and manner stated.
	To the To the Committee of the Committee		29b. Signature and title of certifier	2			29c. Licens		554	De cen		h, Day, Year)
			30. Name and address of person who cor	, MD, Ba	ltimo	re Wa	shington	Medical	Center	- 0,000		,
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re Sar	de S	-				

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		artment of Heal		al Hygier Reg. N	711119	43003
			Decedent's Name (First, Middle, L.	ast)	1,			ate of Death	Day Year	3. Time of Death
	Physici /Medio		LESTER	2.	<i>H</i>	ALL	WE.	L 30	2009	0.1577 M
	Examir	ner	4a. Facility Name (If not institution, gi		± - 1	4b. City, Town, or Loca		4	c. County of Death Howard	
	Funeval		Howard County 5. Social Security Number 6.		yrs. last birthday)	If Under 1 Year If U		ate of Birth Month, Day, Yea		place (State or Foreign
	Funeral Director	Н		1 M 2□ F	56 Yrs.	Months Days Ho	ours Min. (A	Month, Day, Yea $\mathfrak{g} \ 24$, $\ 1$	953 Mar	yland
	pu ,		Usual Residence of Decedent	1400		astion				10d. Inside City Limits
	shov	į.	10a. State 10b. County		. City, Town or Lo					1 ☐ Yes 2√∑ No
	28a-f	rect	MD Howard	1	C01	umbia 10f. Zip Code		10g. (Citizen of What Cou	**
	3a or	Funeral Director	9725 Clocktower	Lane #103		210	46		USA	
	death	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.1	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Specify Y	(es or No-	14. Race - Ameri Black, White,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at		1 Never Married 2 Married	1 ∐Yes 2∆ No If Yes, Give			pecify:	,, 0.0.,	Specify: bla	
21215-0036	hours tural"	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occupation		16b	Kind of Business/ir	ndustry
15	in 72 n "na"	plet	(Specify only highest g	rade completed)	(Give	kind of work done during DO NOT use retired)	g most of working			,
212	filed within Hygiene. Ather than '	ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	di	lsabled			none	
nd	should be filed and Mental Hygies marked other aumatic event, II	Be	17. Father's Name (First, Middle, Las	t)		18.	Mother's Name (Firs	t, Middle, Maid	en Surname)	unk
yla	should I and Men s marke umatic	ပ္	Russell Hall							
Maryland	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship Steven Hall/so			ng Address (Street and More Clocktower			y or rown, State, 21 imbia, MD	21046
d)	t and 2 f Health tem 27 I	100	20a. Method of Disposition	20	b. Place of Dispo	sition (Name of	Date	20c.	Location - City or T	own, State
E	Pages nent or int: If i		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 🕅 Othe r (S pec		cemetery, crer	natory`or other place)	1			
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any Injury or othe		21. Signature of Funeral Service Lice Ronald S	wade Direct	or St	Name and Address of tate Anatomy altimore, MI	Facility y Board 65 0 21201	55 W. Ba	altimore :	Street
			23a. Part 1. Exter the disease r cor shock, or leart failure. List only	nplications that caused the c				piratory arrest,		Approximate Interval Between
	Physician		Immediate Caus (Final	one cause on each line.	m 401	PATHY				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a con	sequence of):	100				
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89	ntifica ng ph as th	Medi	IF FEMALE:							
Вох	death certifi e attending I d for use as	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy			23d. Date of deli	very Day Year
0	00	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5L	Other (specify)				·
σ.	that t ned by detac		Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause given in	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	The law requires that the ate has been signed by th bage 2 should be detache	ed by						1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
ပ္တ	e law requir has been s e 2 should	Completed					2	24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Ä	The I	mo						autopsy performed′ 1 □ Yes 2 🐼	? death?	2 PNo
Vital	Physician: The this certificate rail director, pag	Be	25. Was case referred to medical examiner?				Place of Death (Chi	eck only one)		
of	S S	ျ	1 ☐ Yes 2 ☑ No	1	2 ER/Outpatie		□ Nursing Home			rify)
	ding h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea		f 28c. Injury at Work? M 1 ☐ Yes		Describe how in	ijury occurred	
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Ö	tal or A s after al Direction	Certification:	4 Homicide determine	building, etc. (Sp	оесну)			City or Town, St	ate)	
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (Physician: To the best of my aminer: On the basis of examiner and manner stated.						
	To the within 2 To the сощре	Me	29b. Signature and title of certifier	el his		29c. License nur	mber C	29d.	Date signed (Month	, Day, Year)
			140710	01/0		1)23	10/	1 K	C 30,	2009
			30. Name and address of person who $300~{\cal AMWR}$	y P4 5	NIK	Print) Karlon	MITIM	STEH,	MD 2	1201.
	Sta Regista		31. Date filed (Month, Day, Year) JAN 1 2 2010	32. Registrar's S	ignature Lagran	S. C.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 31, 2009 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) Examiner Montgomer 7. Age 5. Social Security Number 6. Sex **Funeral** Months Hours 1□ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If them 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 No 2
☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) awreni Din9 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12010 Mem Cemeteri 4 Donation 5 Other (Specify) 2. Name and Address of Fality OSEPH L. RUSS 21. Signature of Funeral Service Licensee eral Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death ed by the a 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 Other: P 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054566

State Registrar 9801 Changia Annu #1-17

Silver spring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Sunitra Bhogaville

31. Date filed (Month, Day, Year)

JAN 1 1 2010

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 29c,30 per dr.,g899,01/12/10dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year December Nathan . Medical More 12:45 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death House Social Security Number Kulle Montgomery Birthplace (State or Foreign Country) . Age (In yrs. last birthday) if Under If Under 24 Hrs 8. Date of Birth **Funeral** Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. Director France 38-24-1652 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No lontaomer 10e. Street and Number 10g. Citizen of What Country? Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No No If Yes, Give Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify. Year or Dates white 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VIGORI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Biel doughter Backingham Rd Germantown 1903 091 20a. Method of Disposition 20b. Place of Disposition (Name of Date UUK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3aHimare rematori 21. Signature Juner I Service Licens 22. Name and Address f Facility 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final UN Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 14 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 ☐ Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Mann eath 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 3 🗌 Certifying Nurse Practifying. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D53177 December 16,2009 Rock ville, mel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL 70 MTREZ 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			T- For State of Maryland		rtment of H			iene eg. No. 2009	43006
€.	Physici /Medic		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
>	Examir Funeral Director		4a. Facility Name (If not institution, give spreet and number) NORTHWOSH HOWHAY 5. Social Security Number ORTHODOR OF THE SECURITY NUMBER OF	o hab. set birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	Location of Death In CR 2) If Under 24 Hrs. Hours Min.	8. Date of Mrth (Month, pay,	4c. County of Deat	hplace (State or Foreign untry) unk
	Maryland f show led at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, MD	Town or Loc					10d. Inside City Limits 1 Yes 2 No
	h with the 23a or 28a st be notif	Funeral Director	10e. Street and Number 4601 Pall Mall Road		10f. Zip Code	21215	1	0g. Citizen of What Co	untry?
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes Sive Year or Dates:		Vas Decedent of H i Yes, specify Cuba ☐ Yes 2∏ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	od within 72 ho giene. er than "natu , the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk	16a. Deced (Give) life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor d)	unk king	16b. Kind of Business/	Industry unk
Maryland	rould be file I Mental Hy narked oth	To Be (17. Father's Name (First, Middle, Last)		unk		ne (First, Middle, I		unk
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	460 ace of Dispos	g Address (Street of Pall M. sition (Name of natory or other place	all Road	Baltimoı	ce, MD 212 20c. Location - City or	.15
Baltimore,	permit. P Departme Importan any Injury		4 Donation Mother (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade Diffector	St	Name and Address ate Anato 1timore,	omy Board	1 655 W.	Baltimore	Street
8760,	Physician /Medical Examiner /Medical Examiner / Lausit / Laust	ical Examiner	23a. Part. Enter the disease or corollications that caused the death. shoot or heart failure. List only one cause on each line. Immediate One e (Final disease or condition or resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions of the co	ence of):	er the mode of dyin		or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 68	the death certifica y the attending ph iched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dead of the past 12 □ No	death 3□	Ectopic pregnancy	1		23d. Date of de Month	livery Day Year
	quires that the de in signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not result	ting in the un	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to es 2 □ No 3 □ P	
or Vital Records,	in: The law requir ificate has been si or, page 2 should I	Completed	OSTLOPOVOS.	3		00 Photo (Po		y prior to med? death? 2 No 1 ☐ Yes	utopsy findings available completion of cause of
Division or Vi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 E	28b. Time of Injury	28c. Injur Wor M 1 □	er: 4 Hursing H	28d. Describe ho	ence 6 Other (Special Control of Special Control of	
	he Hospita n 24 hours he Funeral pletely fille	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death on and/or inv	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the corred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To t To t	M	29b. Signature and title of certifier (below M1)	>	29c. Licens	e number 2674		9d. Date signed (Mon.	th, Day, Year)
			30. Name and address of person who completed cause of death (Item 2	1410	Print) FA	LLS a	D BA	HOM	D26211
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 29, 2009 10:22 PMM **Physician** David A. Palm /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 72 June 11, 1937 Pennsylvania 162-28-7338 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the filedical Evantural transition of the 1 ☐Yes 2√ No Director MD Cecil. Perryville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21903 USA 69 Woodall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 mechanic HVAC and Mental Hygie ; marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fill Health and Mental H tem 27 is marked oth William Joseph Palm Emma Laura Moyer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ada Palm/spouse 69 Woodall Road Perryville, MD 21903 permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 Other (Specify) 22. Name and Address of Facility 21. Six alum Eunerel Con Ite I Ronald S State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INFARCTION Immediate Cause (Final disease or condition resulting in death) MYCCARAN AL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☑ No Phospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 N Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I 29c. License number
29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)
12/3027

12/3027

13/107ANATHAN,
203 111 W- HIGH 57

12/107ANATHAN,
192 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-09401 Sandra Phillips

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 43008 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 2, 2009 Medical Examiner Sandra Phillips 2015 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7731 Baltimore Annapolis Blvd Glen Burnie Anne Arundel 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk 5. Social Security Numbet111 K 6. Sex If Under 1 Year | If Under 24Hrs. **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Director Country) 1 M 2X F Oct 31, 1969 Yrs Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 Yes 2 No MD Anne Arundel Glen Burnie Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7731 Baltimore Annapolis Blvd 21060 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: Divorced Specify. white 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than " College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk marked Be ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from St Important: I injury or othe Baltimo permit Page Department Donation 5 X Other Specify: in state re of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ctor Raltimore MD 21201 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or complication **Physician** Approximate Interval List only one cause on each line Between Onset and /Medical Death Methadone and alprazolam intoxication Immediate Cause (Final disease a. Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cau (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical XUNPENDED **AMENDED** attending physician for use as the burial 23a,PII,27,28a-f,perm,E g899 1/28/10 TT IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease Completed 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical or Attending Physician: director, 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ this Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work 28d Describe how injury occurred methadone and Certification: Natural hours after death.

uneral Director:

ly filled in by the fi Pending Yes 2 X No 12/2/09 FD 2010 hrs alprazolam 2X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City or Town State) 7731 Baltimore Annapolis Blvd, Glen Burnie MD 3 Suicide Could not be within 24 hours a To the Funeral I determined (Specify) residence Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. December 3, 2009 30 Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra JAN 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amned 4b, PI line a-b, 28d&f, per ME g900 2/18/10 TI State of Maryland / Department of Health and Mental Hygiene Amend Items 9,11,12,15,16a,17,18,19a,b per sa,g909,11/03/102 0 9 Certificate of Death 43009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1957 PM DAVIO 2009 POWELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Rosedale FRANKLIN SQUARE HOSPITAL BACTIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) MD Months Days Hours Jan 4, 1 X M 2 □ F 214-56-2429 58 **Director** Usual Residence of Decedent 28a-f shov 10a. Stateunk 100 nikside City Limits the Maryland 10b. County 10c. City, Town or Location unk Director unk "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No 10e. Street and Numbe unk 10f. Zip Code unk 10g. Citizen of What Country? Funeral with USA within 72 hours after death unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. à 1 Never Married 2 Married unk 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed ank Medical unk 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filled within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "any injury or other traumating." r than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Layer unk 12 unk-0 Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rosa Revuelta Carl Powell 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code)
1237
23 Medora Road, Linthicum, MD 21090 Franklin Square Hospital David Powell - son 6123 Medora Road, Linthicum, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify) in state 21. Signature of suneral Service Sicensee Thatend Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Atherosclerotic cardiovascular disease immediate Cause (Final Interval Between Onset and Death complicated by hypothermia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hows Coilet Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 🗆 No g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HOMELESS 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 \(\subseteq No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28d Describe how injury accurred Subject exposed to cold environment 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Certificate: ☐ Natural 5 Pending 12/30/2009 Accorder 1645 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined TREET MARLYN AVE 106 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier M. 0 765458 ne and address of person who completed cause of teath (Item 23a) (Type, Print) 9000 21237 MO FLANKLIN SQUARE DRIVE BACTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible. amend #13 Per ANA BD G899 1/29/02/10 JH State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar 43010 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death RAMIREZ Month Physician/ UBFRIT 1900 M Medical 4a. Facility Name (if not institution, give street and number, 4b, City, Town, or Location of Death Examiner 4c. County of Death 1021 Cayer Drive #210 Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 12 M 2 - F (Month, Day, Year Months Hours Min. Director 104-30-0666 69 1940 A112 New Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be a Funeral 1021 Cayer Drive #210 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Puerto Rican, etc.)
Puerto Rican 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: hispanic 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 customer service office depot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Aurelio Ramirez Sr Andrea Alicea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Ramirez/spouse 1021 Cayer Drive #210 Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sign for 1 reral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director un MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, owneart failure. List only one cause on each line. 23a. Part 1 Approximate interval Betwe Immediate Cause (Final Onset and Death CANCER Physician. E disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death signed by the a d be detached f Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> cate has been sig ; page 2 should b Completed 1 🗌 Yes 2, No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of contifier 29c. License number

State Registrar 30. Name and address of person who co

JAN 12

MICHAEL J 31. Date filed (Month, Day, Year) PETENSE HIGHWAY

eted cause of death (Item 23a) (Type, Print

32. Registrar's Signature

VOID

CERTIFICATE

2009-43011

SEE

CERTIFICATE #

2010-01308

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 > 1 43 AM Physician/ ben Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne An BUNNIC * KEHA BURNI 7. Age (In yrs. last birthday) 48 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** D*a*ys (Month, Day, Year) MD Country) 1 M M 2 □ F Months Hours Min. 216-78-9842 2 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director N/A MD Glen Burnie 1 🗌 Yes 2 况 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6906 Glen Ridge Circle 21061 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. African Specify: Armed Forces?

1 Yes Mar No
If Yes, Give 1 X Never Married 2 Married à Je filed within , — ental Hygiene. "--her than "natural", o Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced [®]American Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Food Elementary/Seconday (0-12) College (1-4 or 5+) Chef should be filed with n and Mental Hygien 7 is marked other ti 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisey Mae Smith Leon Smith 1 and 2 should b f Health and Mei tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9801 Lyons Mills Rd, Owings Mills, MD21117 Vera T. Smith/Daughter or other Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Hanover,MD 1/7/10 4 Donation 5 C Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fune al S ice Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NOE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or liniury signed by the attending physician and d be detached for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year law requires that the death Pregnant at time of death 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COUREDIMMUNE DEFICIENC STODRONG 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sral director, page 2 should THRONIC CONDITION OF KIDNEY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform the Hospital or Attending Physician: The I. Ihin 24 hours after death. the Funeral Director: After this certificate h HRONIC DUARRH 25. Was case referred to medical funeral director, 26. Place of Death (Check only one Be examiner Other: 2 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ည Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending Watural. 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JAN 1 1 2010

aren varule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 1 per dr., g899, 01/11/10dhb
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) Frederick 2. Date of Death Robert Tawney Year Physician/ Month 5:32 PM 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 11 mor VA Cente Medica 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 X M 2 □ F Hours Min Director 216-34-6035 Feb. 8.1938 PΑ Usual Residence of Decedent or 28a-f show 10a. Sta permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilth and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Edgemere 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2825 Lodge Farm Rd. Apt. 434 21219 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Never Married 2 Married Black White etc. ģ Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8 yrs. College (1-4 or 5+) Plumber Plumbina Be 17. Father's Name (First, Middle, Last) Charles Tawney 18. Mother's Name (First, Middle, Maiden Surname) Ethel Portner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce West sister 7946 St. Monica Dr. Dundalk Md. 21222 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory or other place, Jan 2,2010 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Si natu of Full al Service I jee 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shook or heart failu Immediate Cause (Final disease or condition Interval Between Onset and Death Physician COPI Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease of linjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an Physician: The law prior to completion of cause of death? autopsy performed' Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending М Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30 AU417643551900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

2. Registrar's Sig

10 M. Greene Freet Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ DOME SUSANNA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 804 JOHNSON GROVE LANE BOWIE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 10 Year 923 Min. Months Days Hours Country) Liberia 1 □ M 2 🗷 Yrs. Director 214-21-3231 86 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Bowie Prince George's Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 20721 804 Johnson Grove Lane Liberia 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Domestic Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sophia W. Toomey Horatio Toomey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20721 Bowie, Md. 804 Johnson Grove Lane Charlotte Farhat / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, Md. 4 Donation 5 Other (Specify) Gate of Heaven Cem. 1-8-10 Funeral Service Lic 22. Name and Address of Facility Capitol Mortuary 21. Signature 20002 1425 Maryland Ave., NE Wash., DC mplications that caused the death. Do for enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, of shock, or heart failure. List br ENEBAU Inset and Death Immediate Cause (Final VASCULAR ACLIDENT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially but conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After: 1. Natural 5 Pending 1 🗌 Yes 2 🗌 No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completed filled in by the fu death. Accident Suicide Investigation 3 🗆 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

30 Name and address of perso

31. Date filed (Month, Day, Year).

141

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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DEYENSE HAHWADANNAPUUS MDZIYU

Box 68760. P.0. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Year **Physician** 12:00 p A Dec 30, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Harford Gardens Raltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Country) 1 □ M 2 🛛 F 2-10-192 Director 255-44-1268 Georgia 88 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other transmitted. 21205 1400 East Madison Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Hansel Ware Nancy Ware 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 Village Lane Nashville, No. Carolina 27852 Melvin Ware 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Md. 01/07/10 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Mausoleum 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failue. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, CMD STAGE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of death? performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 □Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral D 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Worldram Woods Road Mp 21234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Kathleen Montary Ashton 26,2009 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 8899 Stonebrook Lane Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F 06/25/1924 Director 579-26-3648 Wash Usual Residence of Decedent or 28a-f show a notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r Funeral 20019 4534 Dix St., N.E. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Black 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) Homemaker Own Home 12th permit. Page 1 and 2 should be filed witi Department of Health and Mental Hygies Important: If item 27 is marked other I any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Montary Teasley Dennis Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1701 Little Ridge Rd., Hixson, Tenn. 37343 Aileen Harper/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Quantico Nat'l. Cem. 01/05/2010 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. aur S.A NVI 4925 Burroughs Ave .N.E., Washington, D.C 23a. Part 1. Enter the *isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Exam that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimers Dementia has been sig 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page certificate 2 🗌 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Daughter's 2 💢 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Director: After this it in by the funeral dir 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3. Time of Death

10:16 A.

D.C

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

12/29/09

1X Yes 2 ☐ No

Box 68760 P.O. | Records, Division of Vital Hospital or Attending

(Check only one) 29b. Signature and title o

31. Date filed (Month, Day, Year

DEC 3 1 2009

State Registrar

Kathy Brenneman, M.D. 1150 Varnum St., N.E. # 021, Washington, D.C. 32. Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Marse Practioner: To the best of prof knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D0051473

43017 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 2009 11:24 PM Moshe Avrashi /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin <u>Worcester</u> If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Israel If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🛛 M 2 🗆 F 55 Yrs 089-60-9726 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21842 items 23a 105 63rd St. Unit 304 USA Completed by Funeral mit. Pages 1 and 2 should be filed within 72 hours after death aartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23 injury or other traumatic event, the Wedical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gifts Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Haim Avrashi Aliza-Yaffe Alice Yafe ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Idan Avrashi 20 Levi Eshkol St. Tel Aviv, Israel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ramat Hasharon 12/24/2009 Ramat Hasharon, Israel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Fuenral Home 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYCCARDIAL FEW MIMORES INFACCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1⊈Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; of completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

DROTHY

31. Date filed (Month, Day, Year)
DEC 28

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

SNOW HULL MAD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOLZWORTH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #19a, FH, For TCHD, 12/22/09, r1s

mended, #20b, Texture TCHD, 12/21/2009, TLS

Certificate of Death

Reg No. Amended,#20b, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 12 15 12:45P M 2009 Lewis Adams,Jr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dent on der 1 Year | If Under 24 Hrs. ths Days | Hours | Min. | 0 2 - 26 - 1928 Caroline

9. Birthplace (State or Foreign Country) Caroline Hospice 6. Sex 1 M M 2 ☐ F Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 81 Virginia Director 213-24-1945 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mines. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Md. Talbot Director Royal Oak 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5659 Gates Street, Bellevue 21662 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 ☐ Married 2 No 1 🗆 Yes Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Linkwood Elementary/Secondary (0-12) College (1-4or 5+) Saw Mill 10 <u>Stacker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ E. Murray Lewis Adams, SR Sarah 19a. Informant's Name/Relationship (Type. Print)
Patrick Chester
Lewis Adams, III / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1346 Cambridge Beltway, Cambridge, Md. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12-22-2009 1 Burial 2 Cremation 3 Removal from State Veterans Cem. 12-21-09 Hurlock, Maryland Signature of Funeral Service Licensee Bennie Smith Funeral Home 426 Dover Street, Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung cancer IVEAY 4 MONHIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Rother (Specify) He 5pice house 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+VA 8221 Teal Dr., Suit 302, Easton, Md. 21601 David Smith, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Dec 3 oren /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bay Dorchester SingHome Mallarc ambridge Birthplace (State or Foreign Country) 7. Age (In yrd last birthday) Date of Birth (Month, Day, **Funeral** Social Security Number 18-3094 1 M 2□ F 95 Months Days Director May 15 irginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, I'm Mexical Examinal must be notified at 1 ☑Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?
1 ID/fes 2 | No | 9 4 3 USAFuneral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 1 No Specify: Black If Yes, Give Year or Dates: 194 Specify ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Taxi Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malcolm 4nder 50h ဂ္ Marde 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Cambridge, MD. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) pate 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/09 Cambridge, MD Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final) Immediate Cause (Final disease or condition resulting in death) End oral Stell Concer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence off The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) P.0. □Yes 2□No by the 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an has director, page 2 certificate 1 ☐ Yes 2 ☑ No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Urrsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **-** 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this After thi funeral of 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 - Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-14-09 MO30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

503

32 Registrars Signature

TIMWWY

BYRN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 21 per fh, g899,01/28/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number . Age (In vrs. last birthday) **Funeral** Days 1 **X** M 2 □ F 11/06/1939 262-50-6824 Florida 70 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Director MD Prince George's Upper Marlboro 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 5 20772 USA items 23a 11902 North Marlton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █\No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Specify. þ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen M. Halsell John H. Ambrose, Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11902 North Marlton Ave., Upper Marlboro, MD 20772 Department of Health ar Important: If item 27 is any injury or other trau Milo Halsell Ambrose -brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State **Bayview Crematory** 12/22/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee per DVR Veronica Radder 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially that conflicting if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINES burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 ☐ No Hospital: 1 Inpatient Other: $_{4} \square$ Nursing Home 2 ER/Outpatient 3 DOA 5 Residence Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1
Natural during 1 TYes 2 Accident 3 Suicide death. d in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hospita 600 N. Wolte within 24 hours a

To the Funeral C

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Stephen J. 31. Date filed (Month, Day, Year)

JAN 2 8 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ ARBOGAST EDWARD SEPH 2 009 2:28 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HICOTIO SOUSBULG MIN34KA EGIONAL DOICAL If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 🗆 F Min. (Month, Day Ye Months Days Hours **Director** 3a or 28a-f show t be notified at 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shoot traumaft event, the Medical Examiner must be notified at traumaft event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director MANTICOKE 1 Yes 2 No WICOMICC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) rmed Forces?
Yes 2 No 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 1951-1954 Year or Dates WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) EACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve ပ ADIS ARBOGAST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) POSOX GA SFANNETTE APROGIST WIFE 20a. Method of Disposition
1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 21. Signature of Fugeral Service License 22. Name and Address of Facility mm4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Senticemia Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last COPD Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, to 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier only one) 29b. Signature and title of certifier D68222 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 100 E. Carroll St Salsbury MD 21801 R.M.C

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month DEC

68760

Box

P.O.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month D 832M ec 200 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner TNN Appor rundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🔀 M 2 🗆 F Months 5/18/1920 Jacksonville, FI Director 89 579-14-3933 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director 1x Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 745 Governor Bridge Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 💢 No Specify: Black 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Federal Employee Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julius Baker Mary Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. Riley / Daughter Kensington High Naples, FL 34105 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 1/6/2010 Cheltwnham, Maryland any injury . Signatur Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. סבס Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Immediate Cause (Final Onset and Death ASR Physician/ T1030 resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (a a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be del þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No certificate Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 PER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Items 200,26 per fin/dr., 38 no. 1- Registrar Certific	ent of Health and Mate of Death	lental Hygier	2009	43023
	Dharis		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		GEORGE SYLVESTER BALTON		12 24		1940 M
	Examin			City, Town, or Location of Death		c. County of Deat	
-				[EVERLY nder 1 Year │ If Under 24 Hrs.		RINCE	GEORGE 'S hplace (State or Foreign
	Funeral		1 N 2 D F	ths Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Co	untry)
	Director		578-56-5911 67 Yrs. Usual Residence of Decedent		3/27/194	Z WAS	SHINGTON DO
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-fs	cto	MD PRINCE GEORGE'S CAPITOL HE	IGHTS			1 DX(es 2 DNo
	within 72 hours after death with the Maryland jiene. than "natural", or items 23a or 28a-f show the Medical Eveninal must be notified at the Medical Eveninal must be notified at	Director	10e. Street and Number 10f	. Zip Code	10g. (Citizen of What Co	untry?
	ath wi			20743		TED STA	
	tems tems	Funeral	Armed Forces?	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
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ş	tural	ed	15. Decedent's Education 16a. Decedent's	Usual Occupation	16b.	Kind of Business/	Industry
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7	filed within Hygiene. other than '	ĕ	12 PRIN	TER	PR	RIVATE	
and	0 = 0 5	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	en Surname)	
<u>a</u>	should be and Menta s marked umatic ev	2	STEPHEN BALTON	MINNIE	BRANDON	1	
Mar	an ar an		, ,	iress (Street and Number or Rura			
	ss 1 and 3 of Health item 27 other tr			th PL CAPITO			
<u>0</u>			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		/2010	Location - City or	
galtimore,	tt. Pag rtment rtant: I njury o		4□Donation 5□Other (Specify) CHESAPEAKE			ELTSVILI	LE, MD
n B	permit. Pag Department Important: I any injury o			ne and Address of Facility CA MARYLAND AV		ORTUARY VASH., I	OC 20002
			23a. Par 1. Enter the dise se, or a mplications that causes the death. Draw t enter the shock, or heart failur. List only one cause on each line.	mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner	_	Sequentially list conditions.				
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	The I	Completed			performed′ 1 ∐ Yes 2√	? death?	V
VItal	nding Physician: The law th. : After this certificate has b s funeral director, page 2 s	Be (25. Was case referred to medical examiner?		n (Check only one)		
6	Physi this o	ျ	1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐		me 5 Residence		ecify)
ב	ding F	ië E	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Injury M	Work?	28d. Describe how in	jury occurred	
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DIVISION	or A after Direc	Certification:	4 Homicide determined building, etc. (Specify)	story, office	City or Town, St	ate)	arai riodie ivaniber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Co	29a. Certifier Certifying Physician: To the best of my knowledge, death occu (Check only 2 Medical Examiner: On the basis of examination and/or investig:				
	the hin 24	Medi	one) and manner stated.			Date signed (Mont	
	5 v kit	_	29b. Signature and title of certifier	29c. License number			
		- 5	Chiscles of ordaryme	100018	. 10	10/10	12007.
		1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMBREEN SAJJAD SIDDIS	DOOG78	G HOSP	ITAL	
	Sta Registr		31. Date filed (McANy, Yea) 2010 Pegistrar's Signature			-	

DHMH 17 Rev 1/2001

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Funeral Director

Be Completed by

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Physician/Medical Examiner

Be Completed by

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

For	State of Ma	aryland /	•			and M	1ental Hyg	giene				
State Registrar			Certifi	cate of	Death			Reg. No.	20	19	43	024
. Decedent's Name (First, Middle, Last		-1					Date of Dea Month	Dav	12	Year	3. Time	of Death
Helen Eliza		Blake		O'A . T	ul action	d De - ti	Decem			2 0009		
a. Facility Name (If not institution, give	street and number)	t East		City, Town, o	, -	or Death				of Death		
Social Security Number 6. Se	7. Ag	e (In yrs. last b	irthday) If U	Under 1 Year	If Under		8. Date of Birt	:h	İ	9. Birth	place (State	or Foreign
219-34-2917	JM 280 F 7	0	Yrs. Mo	onths Days	Hours	Min.	09-7-9-	<u>*</u> 1°9°3	39	Mar	yland	d
sual Residence of Decedent Oa. State 10b. County		10c. City, Tov	vn or Location	n						~Т	10d. Inside	City Limits
Md. Talbot			East									s 2 □ No
e. Street and Number	•	L		Of. Zip Code				10g. Citi	zen of V	Vhat Cou	intry?	
608 E. Dover S	Street			2160	1			US	SA			
. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was I			igin? (Sp	ecify Yes or No- Rican, etc.)			e - Amer	ican Indian,	
1 Never Married 2 Married	1 ∐Yes 2 ☑11 If Yes, Give			res 2.2811No	Specify:				Specify		ack	
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1.0						16h V:	, ,	ısiness/lı		
15. Decedent's Edu (Specify only highest grad	de completed)		(Give kind	s Usual Occup of work done IOT use retire	during mos	t of work	ing	IOD. KI	וום 10 או	ısıı⊕SS/II	idustry	
Elementary/Secondary (0-12)	College (1-4or 5	5+)		look	,				Наз	rbor	cl:	ub
7. Father's Name (First, Middle, Last)						_	e (First, Middle,	Maiden				
Willie	C	layton			Myr	tle			Joh	nns		
Pa. Informant's Name/Relationship (7) Richard Blake,							al Route Numberston , Ma					
a. Method of Disposition		20b. Place	of Disposition	(Name of		1	Date	20c. Lo	cation -	City or T	own, State	
1 Burial 2 ☐ Cremation 3 ☐	warmough from Ctata		ery, cremator	ry or other pla	ce) !					•		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

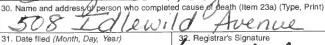
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

HELMIYMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 - State of Maryland / Department of Health and P	Reg	a. No.2 0 0 9	43025
Physician (Madical	1. Decedent's Name (First, Middle, Last) ELIZABETH EUGENIA BOWIE	2. Date of Death Month DECEMBER	Day Year 15, 2009	3. Time of Death 6:45 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 29447 T.TSA DRTVE EASTON		4c. County of Death	
Funeral Director	5. Social Security Number 220-32-1349 6. Sex 1	8. Date of Birth (Month, Day,) 02/02/19	Year) 9. Birthp	lace (State or Foreign try) ARYLAND
or 28a-f show percutified at Director	Usual Residence of Decedent 10a. State			0d. Inside City Limits 1 X Yes 2 □ No
h with th	10e. Street and Number 29447 LISA DRIVE 10f. Zip Code 21601	100	g. Citizen of What Cour	try?
13-0030 72 hours after death with the Maryland 72 hours after death with the Maryland 72 hours after 33a or 28a-f show 61cal Examinar must be rediffed at 16ted by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No Specify: 1 Never in U.S. Armed Forces? 1 No Specify: 1 Never in U.S. Armed Forces? 1	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, e Specify: WH	
within 72 ene. than "na ne Medic	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) R College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	king	6b. Kind of Business/Ind	
the filed of the f	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Ma		<u></u>
Ind yid Ind Id 2 should be file Ith and Mental Hy 27 is marked oth traumatic event	19a. Informant's Name/Relationship (Type. Print) VICKY VANLOO/DAUGHTER 19b. Mailing Address (Street and Number or Ru 8293 GANNON CIRCLE	ıral Route Number, (City or Town, State, Zip	Code)
Dalling e., in Securit. Pages 1 and Department of Health Mportant: if item 27 any Injury or other trans.	20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL PARK 12		Oc. Location - City or To	
permit. Pag Department Important: I any Injury c	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBE 200 SOUTH HARRISON	IN & NEWNA	AM FUNERAL	HOME, P.A.
Ufficate be executed tifficate be executed as the burial-transit as the burial-transit ledical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to time data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on each line. Chronic kidney disease. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Interval Between Onset and Death PeavS
he death cer the attendir thed for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delive	ery Day Year
uires that the signed by ald be detacted by ald be detacted by all by Phresida	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver Cirrhosis		acco use contribute to to	
n: The law requires t firate has been signe r, page 2 should be C			ed? prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Physiclan: T this certificat ral director, ps	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ath <i>(Check only one)</i> Iome 5 Residen) nce 6 ☐ Other <i>(Speci</i> i	(y)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl	27. Manner of Death Manner of Death	28f. Location (Stre City or Town,	eet and Number or Run	al Route Number,
o the Hospital ithin 24 hours o the Funeral ompletely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the ca urred at the time, da	use(s) and manner as stee and place, and due to	stated. the cause(s)
To th withir To th comp	29b. Signature and title of certifier DO 57749		d. Date signed (Month, ecember 16	
)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKSHMI VAIDYANATHAN 505 B DUTCHMAN S LANE, EASTON,	MD 2160	1	,
State Registrar	31. Date filed (Month, Day, Year) DEC 16 2009 32. Registrar's Signature Server B. Sparks			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Otis Bramble December 18 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL Dorches Cambridge Dorchester General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 15, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Maryland 214--34-8948 87 1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1∐Yes 2⊠No Director Dorchester Cambridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 115 Wisteria Drive 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 21215-0036 1 □Yes 21 No Specify: white ≥ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed within Health and Mental Hygiene. farmer agriculture 11 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Otis Bramble Derotha Dunn ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Olive T. Bramble wife 115 Wisteria Drive, Cambridge, MD 21613 permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tro
once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 12/28/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee d w Toloms 700 Locust St., Cambridge, MD 23a. Part1. Elder the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renove **Physician** /Medical Due to (or as a consequence of): Examiner Hypernatremi Sequentially list conditions Examiner If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year for Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 ☐HO certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 047924 12-19-09

State Registrar

Bramble

CAMRRIDGE

SUZ BYRN ST

32. Regisfrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARMAY

NOMAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 13quer December PMA DE CP olche Rae 18 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL 919 BARNEGAT LANE ANNAPOLIS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | FERTIARY 3, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Yrs ŐНІО 80 296-24-1278 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Evanimer must be notified at 1 ☐ Yes 2 📆 No Directo ANNE ARUNDEL ANNAPOLIS MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. any Injury or other traumatic event. It was the mass 23a or any Injury or other traumatic event. 21401 UNITED STATES 919 BARNEGAT LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: WHITE þ Yes. Give 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATHERINE WILMA SOLT DAVID FRANKLIN WOODMENCY မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT H. BAUER/HUSBAND 919 BARNEGAT LANE, ANNAPOLIS, MARYLAND 21401 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Value of Complete Place)

CHESAPEAKE CREMATION DECEMBER 21

CENTER

22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE

D672

ROAD, ANNAPOLIS, MARYLAND 21401

Approximate 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Will E Boun MUUD / Z

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00672 Approximate Interval Between Onset and Death Immediate Cause (Final 1/4/ar carenana an jear **Physician** Heptoce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 🖬 No ţ, 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Ne Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral dir Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 - Natural 1 ☐Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a nd title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) latther ma 1ta 13

32. Registrar's Signature

31. Date filed (Month, Day, Year)

		-	For State Registrar	State of Ma	laryland / Department of Health and Mental Hy Certificate of Death					rgiene UUS 43UZO Reg. No.			
			Decedent's Name (First, Middle)	, Last)					2. Date of Deat Month		3. Time of Death		
	Physicia		Thelma	Delene		1	Barger		December		3:12 A M		
-	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea	th	4c. County of Deat	h		
, and			Western MD Reg	ional Medic	al Ce	nter		erland		Alle			
	Funeral		5. Social Security Number		ge <i>(In yrs. la</i> 36	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) Co	hplace (State or Foreign buntry)		
	Director		216-22-5791 Usual Residence of Decedent	(2.11. 24.		115.			04/17/1	923 Mar	yland		
	and		10a. State 10b. County		10c. City,	Town or Lo	ocation				10d. Inside City Limits		
	Mary Fied	호	MD A	llegany			Cumberla	and			1 □ Yes 2 💢 No		
	7 28a	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	ountry?		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Modical Examirar rust be muffied at		10800 Christi	e Road				21502		USA			
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	>	3. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White			
9	or ite		1 ☐ Never Married 2 ☐ Marr		No		1 □ Yes 21 √ No	Specify:	,	Specify:	-,		
003	ural",	d by	3 ₩ Widowed 4 Divorced	Year or Dates:						W	hite		
<u>7</u>	"nati	lete	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo		16b. Kind of Business	illidustry		
21215-0036	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Homemaker	*/		Home	Home		
d 2	filled Hygi other ent,		17. Father's Name (First, Middle,	_ast)				18. Mother's Na	me (First, Middle, I	Maiden Surname)			
an	ld be ental ked o	To Be	George	Kirk	Но	ott		Alice	Be	atrice	Booher		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar reast be muffled at	-	19a. Informant's Name/Relations	nip (Type. Print)						, City or Town, State,	Zip Code)		
	1 and 2 Health a em 27 is		F. Ann Pyles /	Daughter		P.C). Box 150	01, Ft.	Ashby, WV	26719			
J.e.	of He of He litem		20a. Method of Disposition	o Down of the Chate	CO	ace of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State		
<u><u>ĕ</u></u>	Page ment ant: It		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		MD					Flintsto			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service	icensee						-	Home, P.A.		
80	20 E 20	Ш	Telle	Mars						land, MD	21502		
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each l	d the death ine.	. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Acut	2 days								
	/Medical Examiner		resulting in death)	Due to (or as	a conseque		ontio						
		<u></u>	Sequentially list conditions,	b			encia						
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury		Day to (or as a consequence off):								
<u>,</u>	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	CDue to (or as	s a consequ	ence of):							
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ca		d									
Ó	tifical ng phi as th	ledi	· ·	T						-			
Вох	eath certific attending p for use as 1	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregnanc	ov.		23d. Date of de Month	elivery Day Year		
O. B	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant 9 ☐ Unknown			Other (specify)			MOHIII	Day Teal		
P.(res that the de signed by the	Physician/Medical	9 Unknown Part II. Other significant condition	me contributing to death I	hut not room	lting in the I	Inderlying cause dis	on in Part I	23e Did to	bacco use contribute t	to the cause of death?		
S,	res the	by	Part II. Other significant condition	ins contributing to death i	but not resu	inting in the t	indenying cause giv	emmraiti.			Probably 4 🕅 Unknown		
Vital Records,	w requir been s should	Completed											
3ec	e law has b	nple							24a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of		
a	i; The licate hat, page								1 □ Yes	2 1 ∏No 1 □ Ye	s 2□No		
ΖĦ	sician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			ont 3 🗆 DOA Oth	OF:	eath (Check only or				
ð	Phys rat dii	<u>٦</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 X Inpat 28a. Date of Inj		28b. Time	III 3 LI DOA	4 Li Nursing		ence 6 Other (Sp ow injury occurred	ecity)		
on	ding Ph h. After th funeral	ţi	1 X Natural 5 ☐ Pendin	g (Month, D	ay, Year)	Injury	Wor	kí? lYes 2 □ No		,,			
Division	of or Attency after death Director:	fica	3 Suicide 6 Could	not be 28e. Place of In			treet, factory, office		28f. Location (S	treet and Number or F	Rural Route Number,		
Θ	al or after after Dire	Certification:	4 ☐ Homicide determ	building, e	etc. (Specify	/)			City or Tow	n, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 💢 Certifyin	g Physician: To the bes	t of my know	wledge, dea	th occurred at the t	ime, date and pla	ace, and due to the	cause(s) and manner	as stated.		
	he Ht in 24 he Fu pletel	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s		uon and/or i	iivesuyation, in my	opinion, ueath oc					
	vith To th	Ž	29b. Signature and title of certifie				29c. Licens		1	29d. Date signed (Mor			
	1		Mudda	eem			DO	0066150		December	13, 2009		
			30. Name and address of person Muhhammad Na	who completed cause of em. M.D	death (Item 625 K	1 23a) (Type Kent A	, Print) Lvenue, Cu	umberlan	d, MD 21	502			

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Susan G. Brady Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (UMBERL WMRM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 - M 2 X F Months Hours Director 218-34-2692 March 29, 1936 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Allegany Frostburg Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 204 Braddock Heights Funeral U.S.A 21532- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important, If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) beauty salon beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Christopher Gwenivere Blocher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Leo Brady husband 204 Braddock Heights Maryland Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or Maryland December 23, 2009 Frostburg Memorial Park Frostburg 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. interval Between set and Death Immediate Cause (Final NON SMAN Physician/ disease or condition resulting in death) V1-772 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for this consequence of, Examine and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months
1 Yes 2 1 No Year Pregnant at time of death Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s certificate 1 Yes 2 No Yes 2 L 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending hours after death. Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl rson who completed cause of death (Item 23a) (Type, Print) 912 STONDEIVE CUMBITZLANDMD 21502 31. Date filed (Month Day, Year 32. Registrar's Signatur State 21 2009 DEC Registrar

09-09430 Orvi <u>lle</u> Bent		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib State of Maryland / Department of Health and Mental Hygiene								jible.	ble.2009 4303				
		- For State			-	Cert	ificate	of Death)				g. No.		
Physicia	an/	Registrar 1. Decedent's Nam Orville									2.	Date of Deatl Month December	Day 4, 200	Year 9	3. Time of Death 0322 hrs
Medical Exami		4a. Facility Name (et and number)		4b. City, To	own, or L	ocation of				County of Dea	th
		Doctor's Co			ot and name	,		Lanha					Pri	nce Georg	je's
		5. Social Security I		6. Sex	7. Ac	ge (In yrs. las	st birthday) If Unde	r 1 Year	If Under	24Hrs. 8	B. Date of Birt	h(MM/DI)/YYYY) 9. B	irthplace (State or
Funeral Director				1 X M			20	Months	Days	Hours	Min.	Dec. 27,	1969	Fore C	country) Jamaica
Birottor		228-19-8 Usual Residence		1 X M	² F			113.			<u> </u>				
any	ł	10a. State	10b. County			10c. City,	Town or Lo	ocation							10d. Inside City Limits
*		Maryland	Prin	ice Geo	rae's		Hya	attsvill	е						1 Yes 2 No
rylancylance a-f sh	çç	10e. Street and Nu				<u> </u>		10f. Zip	Code			10	0g. Citize	n of What Co	ountry?
e Ma or 28	Director	6635 24t	h Avenue	<u> </u>				20782					Jamaio	ca	
e death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status			. Was Deceden	nt Ever in U.S	S. 13.	Was Decede	nt of Hisp	oanic Origi	n? (Spec	ify Yes or No	- 1	4. Race - Ame White, etc.	erican Indian, Black,
eath v item	Funeral	1 Never Marr	ied 2 🔀 M	larried 1	Armed Forces Yes	6? 2 X No		If Yes, specif	y Cuban,	Mexican,	Puerto Ri	can, etc.)			
iter de i", or	F	3 Widowed	4 Div	vorced If Ye				Yes 2	_				Specify: Black		
nurs ai ttura	d by	15. Decedent's E	ducation (Spe	cify only hi	ighest grade co	mpleted)	16a. Dece	edent's Usual	Occupati king life.	on (Give ki	ind of wor	k done I)	16b. Kind of Business/Industry		
72 hc	ete	Elementary/Sec	ondary (0-12)		College (1-4 or	r 5+)		Carpente					Con	structio	m
O36	Completed									8.Mother's Name (First, Middle, Maiden Surname)					
5-0036 iled within 72 Hygiene. fother than	ပိ	17. Father's Name		, Last)						18.Mother's Name (First, Middle, Maiden Surname) Pearleta Robotham					
2121 vuld be fi Mental marked	Be	Carl Ber		abin /Tuna	Drint \		I 19b M	ailina Address		earleta Robotham and Number or Rural Route Number, City or Town, State, Z			ate, Zip Code)		
should Martic a	P	19a. Informant's N Esther G.	Bent/W	ife	riuu)			5 24th A							
e, MD 21215-0036 1 and 2 should be filed within 72 hours after Health and Mental Hygiens; item 77 is marked other than "natural"; ritem 77 is marked other than "natural"; r traumatic eveot, the Medical Examiner.		20a. Method of Di	sposition			20b. F		sposition (Nar				Date	20c. L	ocation - City	or Town, State
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiers and soil I filed 21 in and an expectable of the water and only the Medical Examiner must be notified at once or other trammatic event, the Medical Examiner must be notified at once		1 X Burial 2		n 3 🗌 F	Removal from S			or other place eaven Ce		rv	Dec. 200	29, 19	Sil	ver Spr	ing,Maryland
Page ment taot:	H.	4 Donation	6 Other S	Specify:		Gate									2.9,12.2)
imore permit. Pages 1 Department of 1 Important: If injury or other	0	21. Signature of F	uneral Service	e Licensee		0		22 Name and Francis 500 Univ	J. Co	ollins	Funer	al Home Silver	Inc.	ng. MD	20901
		23a. Part I. Enter	the dispase of	r complicat	tions that cause	ed the death	Do not er	ter the mode	of dying,	such as ca	ardiac or r	espiratory ari	est, shoo	ck, or heart	Approximate Interval
Physician /Madical		failure. List o	nly one caus	e on each l	ine. nerosclerotic										Between Onset and Death
Examiner		Immediate Cause or condition resul	(Final diseas ting in death)		to (or as a cor			Disease							
.0				b.											
	ĕ	Sequentially list of if any, leading to	immediate		to (or as a cor	nsequence o	f):								1
	Examine	(Disease or injury	that initiated	· -	to (or as a cor	nsequence o	f):								
xecuted n and l - transit	ä	events resulting i	n death) Last	d.		·	•								
execu an and al - tra	<u>s</u>		D	A	MENDED	_									
, P.O. Box 68760, res that the death certificate be exc signed by the attending physician be detached for use as the burial.	Physician/Medi	IF FEMALE:			23c. If yes, outo	come of preg	nancy							. Date of deli	
Box 68760, e death certificate by the attending physic ed for use as the bur	1 2	23b. Was deceded past 12 mont		the .	1 Live birth		2	Fetal death		Ectopic	c pregnan	су		Month	Day Year
ox 6 ath cel attend	Sici	1 Yes 2		nknown	4 Pregnant 9 Unknown	at time of de	eath 5	Other (Spe	ecify)				- Î		
BC he des	ڄ	Part II. Other sig	_	1			esultina in	the underlyin	g cause	given in Pa	art I.	23e. Did	tobacco	use contribute	e to the cause of death?
P.O. es that the igned by	À											1 🗌 Ye	es 2 🔽	No 3	Probably 4 Unknown
S, F quires en sig	ğ			-								24a. Was		24b. Were	autopsy findings available
ords aw equi as een	a							<u></u>					ormed?	deat	
Rec Th. It.											101	,	2 N	0 1 🗸	Yes 2 No
Division of Vital Records, rai or Atteoding Physiciae: The law "equire is after death. After this certificate has been sind in burth of mane of should in he the finered manes of should in he the finered in the second second in the finered of the second second in her the finered of the second second in the finered of the second se	8		ferred to medi-	cal Hos	nital:					e of Death Other		Home 5	Reside	ence 6 0	Other:
by sic	مِ ا		2 No		. I	atient 2		ne of Injury	DOA	ury at Worl		28d. Describe			
log Pl	ج ا	27. Manner of De			28a. Date of (Month, Da	ay,Year)	200. 111	ie or injury	1 .	Yes 2			•	·	
IVISION or Attendath Director:		2 Accident		ending vestigation	OD - Bloco o	ef leium. At h	nomo farm	n, street, facto	i			28f. Location	(Street a	and Number o	r Rural Route Number, City
ivis lor A after Dire	[3 Suicide		ould not be termined		ii ii ijury - Atri	ionie, iam	i, sireet, lactor	, O 11100	bulluling, o		or Town,			
in 2 a a			e		(Specify) : To the best o	f my lenevile	dae dooth	occurred at the	ne time	date and n	lace and	due to the ca	use(s) ar	nd manner as	stated.
he Fu	Pdical ((Check only one)	Certifying Medical E	Physician caminer:0	: To the best o	examination	age, death and/or inv	estigation, in r	ny opinic	on, death o	ccurred at	the time, dat	te and pla	ace, and due	to the cause(s)
To the within To the	Medical	29b. Signature a		al	nd manner stat	ed.				se number					(Month, Day, Year)
1	*	Table Official Control	^	7	6.0.				0.0	.M.E.			Dec	cember 5,	2009
		30. Name and a	inte U	ine (moleted course	of death /Ito	m 23a)			_					
			ddress of pers Korell MD		mpieted cause istant Medio	cal Exami	ner 1	11 Penn S	treet, I	Baltimor	e, MD 2	21201			
	Stat	_													
	Stat		UEU	28 21	104 De	strar's Signa	p.	gara							

Division or Vital Records. P.O. Box 68760 or Attending Physician:

within 24 hours after death

To the Funeral Director: completely filled in by the f the 2

1011

29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of coefficer MYD December 26, 2009 D62435

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sayed Elsayyad, M.D. 10110 Molecular Drive, Rockville, MD 20850

State Registrar

Medical

31. Date filed (Month

Box 68760 Records, Hospital or Attending Physician: 24 hours after death. Division of Vital

Baltimore, Maryland 21215-0036

To the Vithin 2

Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QAISRANI, NOSHIN, M.D., 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502 ^{Year)} 28

Registrar's Signature

N. Jais ram

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64167

29c. License number

Registrar

Box 68760

P.O.

State

Registrar's Signature

2

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

n al	Registrar 1. Decedent's Name (First, Michael Control of the	ddle. Last)				of Dea		2. Date of Dea	eg. No.	2009	3. Time of De			
_	Susan Broadwate							Month Decemb	Day	2009 Year	10:20 AM			
	4a. Facility Name (If not institut		number)		4b. City, To	wn, or Locat	ion of Death	20001110		County of Deat				
	83 Meshach Frost	Village				Fros	stburg		A	llegany				
	5. Social Security Number	6. Sex 1 □ M 2 X F	7. Age (In yrs.		y) If Under 1 Months I	Year If Ur Days Hou		8. Date of Birth (Month, Day	Year)		thplace (State or Fountry)			
	219-56-7585	1LM 2 A F	59	Yrs.					21, 195	50 <u>Ma</u>	ıryland			
ŀ	Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. Ci	ty, Town or I	Location						10d. Inside City			
ŏ	Maryland A	llegany	Fre	ostburg							1 Yes 2			
Director	10. 01. 11. 1	-			10f. Zip C	ode		1	0g. Citiz	zen of What Co	ountry?			
	83.	Meshach Fros	т v шаде		2153	2-			U.S.A	۸.				
Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13	B. Was Deceder If Yes, specify		c Origin? (Spe	cify Yes or No-	1	14. Race - Ame				
	1 Never Married 2 M	iarried 1 Tes	Sive No		1 ☐Yes 2		ecify:	ilicali, etc./		Black, White	e, etc.			
d by	3 ☐ Widowed 4 🍎 Divorc	ed Year or	Dates:	.	10163 2	L ino ope	ony.			Specify: Wh				
Completed	15. Deced (Specify only high	lent's Education Thest grade completed	d)	I (Giv	cedent's Usual (ve kind of work	done durina	most of workin	g i	16b. Kin	nd of Business	/Industry			
du	Elementary/Secondary (0-12	2) College	(1-4or 5+)		. DO NOT use emaker	retirea)		İ	hom	emaker				
	12 17. Father's Name (First, Middle	U U		HOIII	Ciliakci	18. N	other's Name	(First, Middle,						
œ	Lawrence Minnic						lith Kitzm	,		,				
ို	19a. Informant's Name/Relatio			19b. Ma	o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C						Zip Code)			
	Kari Gomer	daug	hter		0 Parkersb					Maryland				
	20a. Method of Disposition		20b. F		position (Name ematory or other	-		ate		cation - City or	Town, State			
	1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		n State		and Crema		December	28, 2009	Cum	berland	Maryland			
ᅡ	21. Signature of Funeral Servi				22. Name and		acility	I			-			
	John 7	Rapur	ut		Durst Fu	meral Ho	me, 57 Fr	ost Ave.,	Frostb	ourg, MD	21532			
	Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Bett													
	Immediate Cause (Final	(1)	-	MM DO	ardid	In	landi	· com			Onset and De			
	disease or condition resulting in death)	a	o (or as a conseq		<i>Q</i>						2 Lar			
				1,55										
je	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Dire t	o (or es a nomec	nevae-et):										
Examiner	that inhiated events	c	-1											
	resulting in death) Last	Due t	o (or as a conseq	uence of):										
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=	IF FEMALE:	23c If yes	ultcome of prean:		_			23d. Date of delivery Month Day			lia an ma			
ian/I	23b. Was decedent pregnant in the past 12 months?	1 Liv	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) Month 1 □ Live 3 □											
ysician/l	23b. Was decedent pregnant	1 Liv	e birth 2 Feta egnant at time of						2		elivery Day Ye			
y Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1	e birth 2 Feta egnant at time of a known	death 5	5 ☐ Other (spec	cify)	[⊋] art I.	23e. Did to		Month				
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DHMH 17 Rev 1/2

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be

Recent 40	rym parieta	1 Infara	tion	24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of Dea	th (Check only one)	
examiner? 1 ∐ Yes 21 /≦N o	Hospital: 1 Inpatient 2 E	ER/Outpatient 3 DC	OA Other: 4 Officersing H	ome 5 Residence 6	i ☐ Other (Specify)
27. Manner of Death 1	(<i>Month, Day, Year</i>) on	28b. Time of 2 Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	cocurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		me, farm, street, factory	, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	Physician: To the best of my know aminer: On the basis of examinati and manner stated.				

29c. License number D21244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0104 M

Birthplace (State or Foreign Country)
 MD

white

10d. Inside City Limits

MD 21224

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

hour

Year

MD

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BROAD DWAY STREET FRYSTBURG, MD 21532

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 23 2009 32. Registrar's Signature

State

Registrar

Medical Certification: To

			Please	Type or Pri			delible Inkartment of H			-	_		
		for State Registrar		State of M	ai yiai i		rtificate of				eg. NQ 1 1 9	43	036
		Decedent's Name	(First, Middle, La	ist)						ate of Deat	h		of Death
Physicia /Medio		Dougla	S	G.	E	Butts		S	r. <i>1</i>	al Indian	22 09	7.3	35AM_
Examin	er			ve street and number;)		4b. City, Town, o				4c. County of De		
Funeral		5. Social Security No		Sex 7. Ag	ge (In yrs. la	ast birthday)	If Under 1 Year	If Under		ate of Birth			te or Foreign
Director		217-42-6	1001	1 X M 2 □ F	65	Yrs.	Months Days	Hours	Min. N	lov 6,	^{Year)} 1944	Birthplace (State Country)	
and ow t		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						e City Limits
Maryl a-f sho ified a	tor	MD	Alleg	jany		Cur	mberland					1 □ x Y	es 2□No
ith the	Director	10e. Street and Num					10f. Zip Code			1	0g. Citizen of What		
If I I I I I I I I I I I I I I I I I I	eral		ch Street	I do W. Danisland	Francis III	140	Was Daniel of L	215		(0.0 or No	US	merican Indian	
fter de ritem iner r	Funeral	 Marital Status Never Marrie 	ed 2 Married	12. Was Decedent Armed Forces 1 \(\text{Yes} 2	No		Was Decedent of H If Yes, specify Cub.			n, etc.)	Black, WI		,
ral", o	by	3 Widowed	_	If Yes, Give Year or Dates:			1 □ Yes 2 ☑ No	Specify.	:		Specify:	white	
"natu	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during mos	st of working		16b. Kind of Busines	ss/Industry	
withir jiene.	ошо	Elementary/Secon	ndary (0-12)	College (1-4or	5+)	disal		u)			n/a		
e filed al Hyg l'other vent,	Be C	17. Father's Name (!	-			*		Maiden Surname)		
2 should be and Mental is marked or raumatic ev	2		ester H. E						lellie L.	<u>` </u>			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examiner must be notified at once.		19a. Informant's Na JoAnn		(Type. Print) wif	e	19b. Mailii 13	ng Address <i>(Street</i> 86 Arch St	and Numb reet	er or Rural Rou	ite Numbei Cun	r, City or Town, State nberland	MD 2	1502
es 1 ar of Hea of Hear or other		20a. Method of Disp		☐ Removal from State	C6	emetery, cřel	osition (Name of matory or other place		Date		20c. Location - City		
t. Pages trant of lart it ite		4 ☐ Donation	5 Other (Speci	fy)	Sur		morial Park			26/2009	Cumbe	land	MD
Dal permit Depar Impor any in	,	21. Signature of Fu	neral Service Liot	nsee		22	2. Name and Addre Scarp				and, MD 21502)	
	1	23a. Par J. Enter th	ne diseas or con	nplications that cause	d the death	. Do not en						Approxir	mate Between
- Physician		shizck, or hear Imme_late Cause (disease or condition	Final	one cause on each I	ine. Nawy	an	Ley D	isea	Ras			Onset a	nd Death
/Medical Examiner		resulting in death)		Due to (or as	- 1	ence of):	d					1 '	
Lammer	-	Sequentially list cor if any, leading to im-	ditions,	b Due to (or as	a consequ	ence of);						-	
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certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome							23d. Date of	delivery	
death he atte	sicia	in the past 12 1 □ Yes 2 □	months?	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	cy	·		Month	Day	Year
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aw required to should be s	Completed	Onle	omye	lla (R) to	UL			Ĩ.	24a. Was a	in 24b. Were	autopsy findir	ngs available
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Attending Physician: The laver death. Experience of the conflicate has by the funeral director, page 2.	٦. ا	1 ☐ Yes 2 ☐ 27. Manner of Death		1 ☐ Inpat	ury	28b. Time o	nt 3 LI DOA	4			ence 6 Other (5 ow injury occurred	pecify)	
ath. r: Afte	atior	1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, D	ay, Year)	Injury		rk?]Yes 2.□]No				
or Atte	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not I determined	20e. Place of III	jury - At ho	me, farm, sti	reet, factory, office			ocation (S City or Tow	treet and Number of n, State)	Rural Route I	Vumber,
spital o		29a, Certifier	14 Certifying P	hysician: To the besi	t of my kno	wledge, deat	th occurred at the t	ime, date a	and place, and	due to the	cause(s) and manne	r as stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The tribic set is the completely filled in by the funeral director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burnary of the funeral director, page 2 should be detached for use as the burnary and the funeral director.	Medical	(Check only one)		miner: On the basis and manner s	of examinat		nvestigation, in my	opinion, de					se(s)
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43		20 Nome and and the	jus j	completed cause of	death (Ita-	23a\ /T	Print				Dec 2	L, W	4
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieren 43037 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Day December 23, **Physician** Margaret Bailey 1420 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Health Nursing & Rehab. Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0 6 / 18 / 1917 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☑ F Director 173-16-0052 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "netural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be mailtied at MD 1 Yes 2 No Allegany Cumberland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1034 Bedford Street 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Valve Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 Is marked ott Alexander Greig Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. Carolyn Mathews / Daughter 1034 Bedford Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ligonier Valley Cem. 01/02/2010 1 4 ☐ Donation 5 ☐ Other (Specify) Ligonier, PA 21. Signature of Funeral Service Lices 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Ent. the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA **Physician** TWO DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit attending physiclan and resulting in death) Last Due to (or as a consequence of): Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 2 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 29c. License number

leust

Samo

30. Name and address of person who compled cause of death (Item (Type, Print) Robustiano J. /barrera, M.D.,

Lauren

200 Glenn St, Suite 302, Cumberland, MD 21502

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Alvin Bay Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOMICO . Age (In yrs, last birthday, Year If Under 24 Hrs 9. Birthplace (State or Foreign If I Inde 8. Date of Birth Social Security Numbe Funeral (Month, Day, Year) -30-1941 Months 1 🛛 M 2 🗆 F Hours Pennsylvania Director 197-30-4026 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes No Sussex Laurel 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number ö 19956 Funeral 30809 Dogwood Drive items 23a USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates. 'natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mer life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DuPont/ Nylon Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Bay ဂ Sophi Anjeski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 1463 Seaford, Delaware 19973 Joseph Bay (Son) 20a. Method of Disposition
1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) First State Crematory 12-23-2009 Millsboro, Delaware 4 Donation 5 Other (Specify) 700 West St. 21. Signature of Funeral Service Licensee Hally Street-Hanni Hannigan, Short, Disharoon F.H. Laurel, De. 19956 23a. Part 1. Entertitle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastati disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Die to (or se a consequence of) burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical requires that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ģ Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 sl autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 PNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier quiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one d title of certifier 29d. Date signed (Month, Day, Year) 29b

-13 dy

State Registrar 31. Date filed

32. Kegistrar's Signature

of person who

OEC 30

Giller

pleted cause of death (Item 23a) (Type, Print)

31413 WINTERPARE M

SUITE LOS

SKUSBURY MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:05 A M Carolyn Lee Boone 21,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisburg Rehabilitation + Nursing Ctr.
Social Security Number 6. Sex 7. Age (In yrsubst birthda 9. Birthplace (State or Foreign Country)
NC . Age (In yrschist birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 □ M 2 🔀 F 244-62-5777 72 6-20-1937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, It e Medical Extraller must be notified at 1√2Yes 2 No Director Hebron Wicomico MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8714 Island Point Drive 21830 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Black ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Clay Boone <u>Carrie Saunders</u> 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5306 Eastwood Circle, Salisbury, MD 21804 Michael Boone 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State tevens Cemany 12/29/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi 917 W. Isabella St. Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Examil burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown icate has been si ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 KNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 ≥ ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 C M.D. H. William 32. Registrar's Signature ^{Year)}

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie UU 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Dannie Brown 2305 M 18 09 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 32299 Perryhawkin Road Princess Anne Somerset If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1**X**M 2□F 231-70-8762 57 6-11-1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Somerset Princess Anne 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21853 32299 Perryhawkin Road U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) orces? 2 No Marines ve 7/1971 Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TPH Clean Elementary/Secondary (0-12) College (1-4or 5+) Environmental Serv Wkr Venture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorthea Federman Cleveland Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32299 Perryhawkin Rd, Princess Anne, 21853 Emma Brown/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mark's UM Cem 12-26-2009 Oaksville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 11 mos (ancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alcoholism 1. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, or Attending Physician: Hospital

Physician

/Medical

Examiner

Funeral

Director

iteme 23a or 28a-f ehow oar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with neal of Heelih and Mental Hygiene.
ant: If Item 27 is marked other then "naturat", or iteme 23a or ury or other traumatic event, the Medical Examinar marker.

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Physician

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Examiner

Completed by Physician/Medical

Medicai Certification: To Be

3 Suicide

29a. Certifier

4 Momicide

Baltimore, Maryland 21215-0036

Director

Funerai

Be Completed by

the Maryland

page 2 After this certific funeral director, s efter death.
It Director: Af
id in by the fur To the Hospital within 24 hours e To the Funeral I filled IVA

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

mo

29c. License number DZ4986 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riverside Dr. BIOI Salisbury Ad. 560

Registrar

31. Date filed (Month, Day, Year) DEC 28 2009

Reilly

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year Day Month 12 **Physician** 7:40 A M 24 Janice Lynn Cook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Ocean Pines 34 Moonraker Dr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 12/3/1945 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 64 MD 213-46**-**1902 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" ~ " any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event and injury or other event and injury 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 □Yes 21X No Funeral Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 USA 34 Moonraker Dr. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🛛 No 1 ☐Yes 2 No Specify: Completed by white 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Meck Vance Cook ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16541 Red Rock Lane, Broomfield, CO 80023 Kelly Sours / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/31/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilify Burbage Funeral 10me 108 William St., Berlin, MD 21811 Jula Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death 23a. Part 1. Erhor Immediate Cause (Final year sea **Physician** NC disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by atheroscleratic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No es 24a. Was an icate has t page 2 s autopsy performe The certificate l 1 ☐Yes 2 ☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 24, 2009 Kustine Guffin, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33195 Lighthouse Road, Selbyville, DE 1997J 1545 Griffin MD Kristine 31. Date filed (Month State 8 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43042 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 Ollie G. Cotterill December 3:33 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 514 Overhill Drive Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Days (Month, Day, Year) July 17. Months Hours Min. 89 Texas **Director** 465-18-4892 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Virginia Loudoun Leesburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18958 Woodburn Rd. 20175 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Mills Delphia Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla C. LaFever/ Daughter 18958 Woodburn Rd., Leesburg, VA 20175 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3X Removal from State 4 Donation 5 Other (Specify) Jasper, Missouri Waters Cemetery 12/28/09 21. Signature of Junera Solving Hoens 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia vears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ☐ Pregnant at time of death☐ Unknown Month Day Year 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Daughter's 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Home 1 X Natural 5 Pending 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29c. License number

Registrar

State

D21438

445 Defense Hwy., Annapolis, MD 21401

December 21, 2009

Way

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. LaPenta

31. Date filed (Month, Day, Year) **DEC 23 2009**

DHMH 17 Rev 7/2009

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 December 10:15 P™ Carole Ann Collier /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/20/1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Months Days Hours Min. Yrs. Maryland 67 Director 215-44-4311 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 □Yes 2 X No Director Maryland | Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21108 614 Stone Wheel Ct., Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ∐Yes 2**X** No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Draftsman Civil Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once. Elizabeth Strippy William Eugene Cornell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walter G. Collier/ Husband 614 Stone Wheel Ct., E, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 12/29/09 4 ☐ Donation 5 ☐ Other (Specify) |Crownsville, MD 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home Wolla 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause of the conditions of the cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely lifted in by the Invertal director, page 2 should be detached for use as the burlat-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not res ing in the underlying cause given in Part I. Division of Vital Records. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes → No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28b. Time of Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signatu 29c. License number 29d. Date signed (Monty, Day, Year)

State

Registrar

rson who completed cause of death (Item

32. Régistrar's Signature

D16376

			1 - For State Registrar	State of M	•	epartment of F Certificate of		, ,	ne No.2009	1,301,4
	200	- 1	Decedent's Name (First, Middle, La	st)				2. Date of Death	W-2 0 0 J	3. Time of Death
	Physici		LOUISE	ROSE	COIRO			December	23, 2009	11:53 A M
SV a	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. County of Deat	h
7	LAdiiii	ici	Alice Byrd Tawes			Cri	sfield		Somer	set
makey a	Funeral		5. Social Security Number 6. S		ge (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birtl	hplace (State or Foreign
m	Director		056-32-3647	I□M 2📈 F	69 Yr	s. Months Days	Hours Min.	(Month, Day, Ye	,1940 New	untry) Vork
			Usual Residence of Decedent		09			march 20	71340 NCW	TOLK
	yland		10a. State 10b. County		10c. City, Town of	or Location				10d. Inside City Limits
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	r 28e	Director	10e. Street and Number	266		10f. Zip Code		10g.	Citizen of What Co	untry?
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	mus 2	Funeral	116 Somers Cove	12. Was Deceden	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub.		pecify Yes or No-	14. Race - Ame	rican Indian,
	r iter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☑		If Yes, specify Cub	an, Mexican, Puèrt	Rican, etc.)	Black, White	e, etc.
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b	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)		TVULSE	18. Mother's Nam	e (First, Middle, Mai		y
an	d be ental ced c	To B	Joseph DeCresce	n20			Mary Fi	dieras		
<u>-</u>	shoul mari	F	19a. Informant's Name/Relationship (19b. N	Mailing Address (Street		-	ity or Town State 2	7in Code)
\mathbf{z}	ith ar 1th ar 27 Is trau		Florence Weissq			61 3rd Stre				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	20b. Place of D	Disposition (Name of	7		. Location - City or	
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			Mary Beth Bra	Shaw Pru	Act C	<u>306 W. Ma</u>	in Street	<u> – Cristi</u>	eld, Mary	rland 21817
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ဖ		Me	IF FEMALE:	00- 1/					T	
Вох	ath o ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pregnanc	у		23d. Date of del Month	ivery Day Year
0	uires that the death certifii signed by the attending i d be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐Unknown	at time of death	5 ☐ Other (specify) _			i i i i i i i i i i i i i i i i i i i	Day 10a.
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Vita	Physician: The lav this certificate has al director, page 2	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
>	nyslo	ToE	1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outp	atient 3 DQA Oth	er: Nursing H	ome 5 ☐ Residenc	e 6 □Other (Spe	cify)
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D			y at	28d. Describe how	injury occurred	-
<u>ত</u>	ath. or: At	atic	2 ☐ Accident investigation	n		*	Yes 2 □ No			
Š	I or Atten after death Director: I in by the	tific	3 Suicide 6 Could not b 4 Homicide determined	20e. Flace Util	jury - At home, farm	n, street, factory, office		28f. Location (Stree City or Town, S		ıral Route Number,
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	Hospital 24 hours 2 Funeral istely filled		29a. Certifier Certifying Pl	nysician: To the bes	of my knowledge, of examination and/	death occurred at the ti or investigation, in my o	me, date and place	, and due to the caus	se(s) and manner as	s stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	one)	and manner s	tated.		opinion, death occu	ned at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	2.		29c. Licens	e number	29d.	Date signed (Mont.	h, Day, Year)
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- (5		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	ype, Print)	111	111		0 20
)		MICHAEC	ATKI	NS /m	- (IALL.	Clytrush	J Crus;	old nin
	Sta		31. Date filed (Month, Day, Year)	32, Regist	rar's Signature	hours			*	21817
	Registr	ar	DEC 282	LUUJ KURNU	we p.	Marin				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER. 20 \mathbf{A}^{M} MARY LOIS COCKEY 2009 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 224 BENTONS PLEASURE ROAD CHESTER OUEEN ANNE'S Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Month, Day, Year 1 D M 2 X F Days Director 214-14-2245 89 Yrs. MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND **OUEEN ANNE'S** CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 224 BENTONS PLEASURE ROAD UNITED STATES 21619 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗷 No 0. Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Tes 2 X No Specify: If Yes, Give "natural", Specify: 3 XWidowed 4 Divorced WHITE Year or Dates Medical Decedent's Education. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within SECRETARY DEFENSE CONTRACTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ FRANK BARTLET COCKEY MIRIAM ROSEBUD STEVENS and N 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JOHN THOMAS COCKEY/SON 222 BENTONS PLEASURE ROAD, CHESTER, MARYLAND 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ᇹ = 6 Department of Important; If any injury or once. 1 X Burial 2 Cremation 3 Removal from State DECEMBER 26 4 Donation 5 Hother (Specify) STEVENSVILLE CEMETERY 2009 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 06 SHAMROCK ROAD, CHESTER, MARYLAND 21619 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, alturation is tonly one cause an each list. 23a, Part shock, or h Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ NEUMONIA WEEKS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): transit. Cause (Disease or illingery that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Vear signed by the a 1 Yes 2 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? SEIZURE DIJSKOEM 24a. Was an this certificate has al director, page 2: autopsy performed? Yes 2 No Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Division 1 Yes 2 No Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 33 ELEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMIE SALLITT STEVENSVILLE 21666 31. Date filed (Month 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CARLA CLIPP DECEMBER 2009 7:14A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 871,971941 Brunswick MD Director 68 218-38-2170 Usual Residence of Decedent show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 X No Frederick Frederick MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21703 120 Burgess Hill Drive items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. "natural", or à 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bank Teller Damascus Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Lillian Manzella Brown Carl Edward Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Knoxville MD. 21758 2516 W Boss Arnold Rd. Terri Cooper, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 & any injury or 1 X Burial 2 Cremation 3 Removal from State 12/26/2009 Frederick MD 4 Donation 5 Other (Specify) Rest. Mem. Gardens permit. 21. Signa ure of Fune Service License 22. Name and Address of Facility Kallara John T Williams Funeral Home, Brunswick MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 0014 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Emphyene, History of Manpropriate SThis tachycarda Completed Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate decentiano Division of Vital filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Hospital or Attending Natural 5 Pending work? death. Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nu my 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Je, BRUNSWICK, MD 21716 CHAN 610 9th MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State		State o	f Mar	yland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>		Mental Hy	giene. Reg. No.	2009	43048
		Registrar 1. Decedent's Name	(First, Middle	, Last)					2. Date of De	ath		3. Time of Death
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Examine		4a. Facility Name (If		_			4b. City, Town, or	Location of Death			County of Deat	h
		€		ursing Care C		· · · · · · · · · · · · · · · · · · ·	If Under 1 Year	Frostburg If Under 24 Hrs.	0 Data of Bi		llegany	hplace (State or Foreign
Funeral Director		5. Social Security Nu 212-01-982	23	6. Sex 1 □ M 2 🙀 F		(In yrs. last birthday) 93 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, D. Decembe	ay, <i>Year)</i> τ 12, 19	Co	aryland
land ow t	ŀ	Usual Residence of 10a. State	10b. County		1	0c. City, Town or Lo	ocation					10d. Inside City Limits
Mary -f sho fled a	ţo	Maryland	Alle	gany		Frostburg						1 X Yes 2 □ No
h the or 28g	Director	10e. Street and Num	nber 100 H	loneysuckle	Lane		10f. Zip Code			10g. Citiz	en of What Co	untry?
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	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed	_	If Yes, G	orces? 2 X No ive	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 14 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		 Race - Ame Black, White Specify: 	e, etc.
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82589		1/10	des)	D JOE	5		Durst Funer	al Home, 57	Frost Ave	, Frostl	ourg, MD	21532
		shock, or hear	rt failure. List o	complications that only one cause on o	caused the	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician //Medical		Immediate Cause (disease or condition resulting in death)		-a. Enc	15/		ementra					2 years
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Attending Physician: The law requires that the death certificate be executed reath. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 5 9 ☐ Unknown	months?		birth 2 nant at ti	Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у		2	3d. Date of de Month	livery Day Year
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equire en sig	ed b								1 🗆	Yes 2]No 3□P	robably 4 Unknown
The law re ate has be page 2 sho	Completed								24a. Was auto perf 1 🗆 Yes	s an psy ormed? 2 2 No	24b. Were an prior to death?	utopsy findings available completion of cause of
cian: ertific ector,	Be	25. Was case referr examiner?	ed to medical					26. Place of Dea		\rightarrow		
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s after	Certification:	4 Homicide	dotomi	build	ling, etc.	(Specify)			City or To	wn, State)		
	Medical (29a. Certifier (Check only one)	2 Medical I	Examiner: On the	pasis of e	my knowledge, dea xamination and/or ind.	nvestigation, in my o	pinion, death occu	irred at the time	, date and	place, and due	e to the cause(s)
To the To the Country of the Country	ž	29b. Signature and	title of certifier	.Dal.	-	6.11	29c. Licens	e number	2	29d. Date	signed (Mon	th, Day, Year)
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nows		30. Name and address	ess of person v	who completed cau	se of dea	th (Item 23a) (Type,	ex wills	h Rd C	umhe	Man	el M	th, Day, Year) -009 D21502
Stat Registra	e ir	31. Date fig ECont	17 200	9 Denni	registrar's	s signature	<i>y</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18, 2009 Wilfrid Cherubin 10:10 p M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) (Month, Day) ^{Year}1951 Days 1 🖾 M 2 🗆 F 073-66-0898 57 Director Haiti Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖁 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14407 Innsbruck Court 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Completed Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Manager Building Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Canje Cherubin Tciana Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14407 Innsbruck Court, Silver Spring, MD 20906 Laurente Cherubin/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 28 1 XBurial 2 Cremation 3 Removal from State Dec. 2009 Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Other (Specify) Ç 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Tachycardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pancytopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami burial-transi Metastatic Prostate Cancer that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be phy: the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes ∠ L g ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metabolic Encephalopathy Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🕱 No ဂ္ 1 🏝 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.
I Director: A
d in by the fu Accident 1 Tes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Direct

completed filled in by Medical 29a, Certifier ੌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

31. Date filed (Month 1) Property

Winnifred Lee, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of

32. Begistrar's Signature

29c. License number

D67901

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

Box 68760

P.0.

Division of Vital

State of Marvland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 1:18 P M CLARENCE CALDWELL DEC. 22. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
SEPT. 25,1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 XM 2 □ F Months SEPT. VIRĞINIA Director 231-38-6514 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f show event, the Modical Experience, ust be retiried at 1 XYes 2 No Director MD. PRINCE GEORGE'S LANDOVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 7202 EAST FOREST RD. 20785 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☐YNo Specify Specify: ≥ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 12 should be filed w th and Mental Hygier 7 is marked other th PRINTER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CALDWELL traumatic ဂ ROBERT F. LUCILLE SNYDER Department of Health and I hoportant: If item 27 is manany injury or other traumations. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. CALDWELL/WIFE 7202 EAST FOREST RD., LANDOVER, MD. 20785 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 12-29-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licerises 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, MD. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate I 1 □Yes 2 □ No 1 ☐ Yes Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12/24/09 P20905 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallaut Fox lane Bowie Mb 20715 Champaloux MD

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Virginia Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ Ę Months Days Hours Director 213-24-5854 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-1 shov raumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Cumberland MD Allegany 1 ☐ **X**es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 East Elder Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 XVidowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Doctor's office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Crites Sally George Crites permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Barrett gr.daugh. 26 East Elder Street Cumberland MD 21502 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Davis Memorial Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/30/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CUU disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner ff any, leading to min ediate cause. Enter Underlying Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? 2 M ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending WORK? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie certifying Physiciam To the best of my I/nowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State **DEC 29** 2009 are Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

23

2009

32. Pegistrar's Signature

09-09987 Michael John Conn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aei John Co		1- For State Registrar Certificate		Reg. No. 20	09 4305
Physici dical Exami	an/	1. Oecedent's Name (First, Middle,Last)		2. Oate of Death 22 Month Oay Year December 21, 2009	3. Time of Death 2030 hrs
		Facility Name (if not institution, give street and number) Harbor Hospital Center	4b. City, Town, or Location of Dea Baltimore	th 4c. County of	Oeath
Funeral Director			Months Oays Hours M		9. Birthplace (State or Foreig Country) Maryland
land f show any once.	tor	,	Len Burnie		10d. Inside City Limit
the Mary 3a or 28a- otified at	Director	10e. Street and Number 315 Clear Drop Way	10f. Zip Code 21060	10g. Citizen of What United St	
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Upperment of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer Yes 2 No specify:	to Rican, etc.) White,	American Indian, Black, etc. White
hin 72 hours a e. than "natura edical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind og most of working life. DO NOT use κ		•
Mental Hygiene. marked other than cevent, the Medica	o Be Con	17. Father's Name (First, Middle, Last) Richard Matthews Conn, Sr.		ne (First, Middle, Maiden Surname) .a Anne Shilow	State Zin Code)
nd 2 shoul alth and N m 27 is n	Ţ	Richard M. Conn, Sr./Father 202	Pennick Drive, S	tevensville, Mar	
paritimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	77	1 Burial 2 X Cremation 3 Removal from State Kalas Cr		/31/2009 Edgewat	er, Maryland
	V	Miller	2973 Solomons Isl	and Road, Edgewa	ter, MD 2103
hysician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Oo not ent failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Narcotic (morphine) Oue to (or as a consequence of):		or respiratory arrest, shock, or near	t Approximate Inter Between Onset a Death
	Examiner	Sequentially list conditions, if any, leading to immediate abus. Enter Underlying Caust (Disease or injury that initiated			
ecuted and transit		events resulting in death) Last Due to (or as a consequence of):			
cate be ex physician the burial		iF FEMALE: 23c. If yes, outcome of pregnancy	a-f,permE, G899 1	./15/10 TT 23d. Date of d	
e death certificate be executed the attending physician and ed for use as the burial - trans	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic preg Other (Specify)	nancy Month	Oay Year
ires that the signed by t d be detache	þ	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	-	Probably 4 V Unknow
In a region of the factor of the factor of the factor of the factor of the factor of the factor of the factor. In the factor of the factor of the factor of the factor of the factor of the factor of the factor, page 2 should be detached for use as the burial - transit of the factor	Completed			autopsy pr performed? de	ere autopsy findings availa ior to completion of cause o eath? Yes 2 No
ysician: this certifi director,	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpat	26.Place of Death (Checkett) ient 3 DOA Other Mur	ck only one) sing Home 5 Residence 6	Other:
To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page 5	Certification: To	27. Manner of Oeath 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time 28d. Date of Injury (Month, Day, Year) Fd 12/21/09 Fd 7	30 pm 1 Yes 2 X No	28d. Describe how injury occurre unk	
Hospital or A 24 hours after Funeral Directely filled in b	Certific	3 Suicide 6 X Could not be determined (Specify) House		28f. Location (Street and Number or Town, State) 315 Cl Glen Burnie, MD	
Fo the Ho within 24 Fo the Fu	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation on the basis of examination and/or investigation on the basis of examination and/or investigation.	tigation, in my opinion, death occurre	d at the time, date and place, and du	e to the cause(s)
	N	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signe December 2	d <i>(Month, Day,Year)</i> 23, 2009
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 212	01	
S [.] Regis	tate trar		10		
H 17 Rev 1/2	OUT	ORIGI	NAL	0045	

			1 - For State Registrar	State of Maryla	-		nt of He <i>te of D</i>		Mental H	ygiene Reg. No.	2009	43054
			1. Decedent's Name (First, Middle, Last,						2. Date of D Month	eath Day	/ Year	3. Time of Death
м	Physici /Medi		Ellen J. Champio	n					Decemb		9, 2009	2:00 P M
No. of Street,	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City	Town, or L	ocation of Deat	h	4c.	County of Death	
			5000 Jasmine Drive			Roc	kville		1	Mo	ntgomery	
	Funeral		5. Social Security Number 6. Security Number 141–14–1673	ไห อใช้เ⊏	s. last birthday) QQ Yrs.	Months		If Under 24 Hrs Hours Min.	8. Date of B (Month, L June 2	orth Day, Year)	Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		88 Yrs.				June 2	20, 1	921 New	Jersey
	yland		10a. State 10b. County	10c. 0	City, Town or Lo	cation	-					10d. Inside City Limits
	a-fs	ctor	MD Montgomer	y Ro	ckville	<u> </u>						1 □Yes 2X No
	or 28	Jire	10e. Street and Number	•		_	p Code			10g. Cit	izen of What Cou	ntry?
	23a 23a ust b	la l	5000 Jasmine Drive	!		20	853			USA		
	tems	nue nue		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 💆 No	U.S. 13.	Was Dece If Yes, spe	dent of His	panic Origin? (S , Mexican, Puer	Specify Yes or Noto Rican, etc.)	10-	 Race - Ameri Black, White, 	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show ileal Evandruc rust be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐ Yes 2 ⊠ No If Yes, Give Year or Dates:		1 □ Yes	2 X No	Specify:			Specify: Whi	to
21215-0036	tural tural	ed	15. Decedent's Edu		16a Dece	dent's Usi	ual Occupat	ion		16b. Ki	ind of Business/Ir	
215	nin 72 n "na	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed)	(Give	kind of wo	ork done du ise retired)	ring most of wo	rking		The or Education	
212	d within giene. er than "	E	12	College (1-4or 5+)	Homen	aker				Ow	n Home	
pu	al Hy lothe	Be	17. Father's Name (First, Middle, Last)					8. Mother's Nar		e, Maiden	Surname)	
yla	ould be f Mental I arked of	은	John Francis Farre	11			F	Ruth Tit	cus			
Maryland	2 sh		19a. Informant's Name/Relationship (Ty	pe. Print)		_					or Town, State, Zi	p Code)
6,	and Health		Jo-Ann Smits	l a a				cive Roo	·	_		
lor	Pages 1 ment of h ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ F		Place of Dispo cemetery, crei				Date		ocation - City or T	
Baltimore,	it. Pa rtmei rtant rjury		4 □ Donation 5 □ Other (Specify)					atory 12			dbine, M	
Ba	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service License	IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	G ⁶	ing	Home (rematio	on Servi	ice :	P.O. Box	784
			23a. Part 1. Enter the disease, or compli	cations that caused the dea							rksville	Approximate Interval Between
3	Physician	3 3	shock, or heart failure. List only or Immediate Cause (Final				, ,		. ,		1	Onset and Death
*	/Medical		disease or condition resulting in death)	Colon Cance Due to (or as a conse								5 years
	Examiner				,							
	± σ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):							
	ecute and -trans	Examiner	that initiated events resulting in death) Last									
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	E)	Toodang at doday Last	Due to (or as a conse	equence of):							
387	physics the I	edical										
Box (certif ndjing Ise ak	/Me	IF FEMALE:	3c. If yes, outcome of preg	nancy						23d. Date of deliv	zerv.
ğ	death atte	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		☐ Ectopic ☐ Other (s	pregnancy pecify)				Month	Day Year
P.0.	at the de by the tached	hysi	9 Unknown	9 Unknown								
S,	res tha signed be det	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying	cause given	in Part I.	23e. Did	tobacco t	use contribute to	the cause of death?
Records,	v require been signature should b								1 🗆	Yes 2	□ No 3□ Pro	bably 4 Unknown
ecc	a law re has be e 2 sho	Completed							24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
H	: The cate ha	mo.								formed?	death?	
/ita	sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?				T	26. Place of Dea				
of Vital	Physician: r this certifica ral director, p		1 ☐ Yes 2 X No	ospital: 1 Inpatient 2[_			4 LI Nursing F	lome 5 Re	sidence	6 ☐ Other (Spec	ify)
n c	ding F h. After funera	on:	27. Manner of Death 1 Natural ∑ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f :	28c. Injury a Work?		28d. Describe	how injur	y occurred	
isio	vttendi death. ctor: / y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	00a Blood of Injury At	hama farm atr	M not factor		s 2 No	OOS Leastion	(04	d Museh en en Du	Deute Musel
Division	or A after Direc	Certification: To	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, larm, str	eet, ractor	у, опісе		City or To	(Street and Swn, State	n a Number or Hui r)	al Route Number,
_	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		29a, Certifier 1X Certifying Phys	siclan: To the best of my kr	nowledge, deat	h occurred	d at the time	e, date and plac	e. and due to th	e cause(s	and manner as	stated.
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation	n, in my opi	nion, death occi	urred at the time	e, date and	d place, and due	to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	11. 1	0		c. License i				te signed (Month	
			Joseph M.	Haggerty n	26).	I	032407	7		Dece	mber 21,	2009
	2	Ì	30. Name and address of person who co									
			Joseph Haggerty, M			nter	Dr. F	Rockvill	.e, MD 2	0850		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	to Mand	,					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

P	hys	ician
	/Me	dical
E	Exan	niner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it all soften Examinations to rectified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Sta Regist

	For State Of Walfylar Registrar		ertificate of		nomai m	Reg. N	ZHHA	43055
	1. Decedent's Name (First, Middle, Last)				2. Date of De		ov V	3. Time of Death
ian ical	Janet Larsen Day				Decembe:		ay Year 2009	4:25 AM ^M
ner	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, o Laurel	r Location of Death			c. County of Dea Prince Ge	
Г	5. Social Security Number 6. Sex 7. Age (In yrs. 1 M 2 T F 95	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D May 7,	rth ay, Year 1914	9. Bi	rthplace (State or Foreign country) OokLyn, NY
	Usual Residence of Decedent							Transition in the
5		ty, Town or L turel	Location					10d. Inside City Limits
ecto	10e. Street and Number	idi Ci	101 7: 0:1:			10 0	NA	1 ☐ Yes 2√ No
ral Dir	9001 Cherry Lane		10f. Zip Code 20708			iug. C	itizen of What C	ountry?
nne	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:			Specify: Wh	
pletec	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dec (Giv life.	edent's Usual Occup re kind of work done DO NOT use retire	pation during most of work d)	ing	16b. I	Kind of Business	s/Industry
S E	12	Home	emaker				Own Home	
Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	. ,	, Maide	n Surname)	
2	Gabriel Larsen			Anna	Nelsen			
	19a. Informant's Name/Relationship (Type. Print)	1	ling Address (Street			_		Zip Code)
	Richard W. Day Son		OO Bignonia		<u>-</u> _			T 01-1-
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, cre Wash.	oosition (Name of ematory or other plac Crematory,	Inc. 12/15	Date 5/2009		Location - City of aurel, Mar	
	21. Signature of Funeral Service Licensee M01283		22. Name and Addre Fleck Funera				1 1 00	707
	23a. Part 1. Enter the diseal e, or commissed in that caused the deat shock, or he art failure. List only one cause on each line.	h. Do not e	7601 Sandy S nter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,	ryland Z	0707 Approximate
	Immediate Caus (Final							Interval Between Onset and Death
	disease or condition resulting in death) a. Canlin Resulting in death) Due to (or as a conseq	spirator uence of):	ry Arrest					
	Pulmonary							
ner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events	uence of):						
ami	Cause (Disease or injury that initiated events c.	···-						
calE	resulting in death) Last Due to (or as a consequence of the consequenc	uence of):						
edi								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome of pregnate 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 0 9 □ Unknown	I death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			23d. Date of de Month	elivery Day Year
y P	Part II. Other significant conditions contributing to death but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	to the cause of death?
q pa					1 🗆	Yes 2	2 □ No 3 □ F	Probably 4 🔀 Unknown
omplet							prior to death?	utopsy findings available completion of cause of
Be C	25. Was case referred to medical examiner?			26. Place of Deat	1 ☐ Yes h <i>(Check only</i>		1	
	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA Oth	er: 4 ☐ Nursing Ho	me 5 Res	idence	6 □Other (Sp	ecify)
ü.	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time Injury		y at k?	28d. Describe	how inju	ury occurred	
cati	2 Accident investigation			Yes 2□No				
Certifi	4 Homicide determined 28e. Place of Injury - At the building, etc. (Specification)	ome, farm, si	treet, factory, office	ļ	28f. Location (City or To	Street a wn, Stai	und Number or F te)	Rural Route Number,
Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of my knd one) Certifying Physician: To the best of my knd one in the basis of examines and manner stated.	wledge, dea ition and/or i	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	cause((s) and manner and place, and du	as stated. e to the cause(s)
Ĭ	29b. Signature and title of certifier)	29c. Licens			29d. D	ate signed (Mon	ith, Day, Year)
	Molen Tout			69247		12	1291	3000
	30. Name and address of person who completed cause of death (Iter Mohamed Tourky, MD 7300 Va	n 23a) (Type n Dusen	n Road, Laur	el, Maryland	d 20707			
ate rar	31. Date filed (Month, Day, Year) DEC 3 1 2009 Lucy 1. 32. Registrar's Signary	ture						

			For State			d / Depa		t of H	lealth	and N	lental Hy	giene	nn	9	43	056
			Registrar 1. Decedent's Name (First, Middle	e. Last)		Cei	runcai	e or t	Jeam		2. Date of De	Reg. No.			-	of Death
	Physici		Alva Geraldine								December	r 18	20) 09 °		01 АМ м
-	/Medid Examir		4a. Facility Name (If not institution	n, give street and nui	mber)				Location	of Death				of Death		
- Age			Laurel Regional					aurel	18 11	04115			ince	Geor	_	
b	Funeral Director		5. Social Security Number 550-34-3167	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 84	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir March 20	3, Year) 3, 192	5	9. Birth Cou Missi	place (Sta intry) SSippi	te or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside	City Limits
	Mary a-fsh	ctor	Maryland Anne A	Arundel	Lau	rel									1 □ Y	es 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it w Mudical Evanter must be notified at once.	Completed by Funeral Director	10e. Street and Number 3396 Fountain Gree	en South			10f. Zip		724			10g. Citiz	zen of W	/hat Cou	intry?	
	ems 2	ner	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Dece	dent of Hi	ispanic Or	igin? (Sp	ecify Yes or No Rican, etc.))- 1		e - Amer k, White	ican Indian	1
36	s after , or its	y Fu	1 Never Married 2 Marr	ried 1 □Yes	2XXNo	1	1 □ Yes		Specify:		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify.		ack	
9	hour:	ed b	3 X Widowed 4 □ Divorced	Year or D	ates:	16a. Dece	dent's Usua	al Occupi	ation			16b. Kir	nd of Bu			
215	hin 72 e. an "na Modis	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	during mos ()	t of work	ing				•	
21	filed wit Hygien other the	Con		2		Ch	ildcar	e Pro						dcare	2	
land	ild be fill fental H rked oth	To Be	17. Father's Name (First, Middle, Louis Cardreon	Last)							e (First, Middle) exander	, Maiden S	surnam	e)		
Maryland 21215-0036	and 2 should the eath and Men Men 27 is marked ier traumatice		19a. Informant's Name/Relations Yvonne Jones	hip <i>(Type. Print)</i> Daughter			0	,			al Route Numb			,		
ře,	s 1 ar		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crei	sition (Nar	ne of ther plac	e) :	ı	Date	20c. Loc	cation -	City or T	own, State	
Baltimore,	Page Iment tant: It		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Mai	cyland V	et. Ce	meter	У		9/2009				Mary1	and
Ball	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature of Funeral Service	Livensee	MOIZI	3 F	leck F	unera	s of Facili 1 Horme	e, Inc	/601 S	Sandy 1, Mar	-	-		
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that e	aused the deat ach line.	h. Do not ent	ter the mod	de of dyin	g, such as	cardiac	or respiratory a	arrest,			Approxin Interval I	nate Between nd Death
" A	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a,	erosclero		onary	arter	y die	ease						ia Boatti
	Examiner			Due to	or as a conseq	uence of):										
	₽ .±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	or as a conseq	uence of):										
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	uence of):		*								
760,	te be executed ysician and e burial-transit	calE		L _d	or as a someoq	401100 017.										
89				u												
P.O. Box	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【V No 9 ☐ Unknown		oirth 2 ☐ Feta nant at time of o	ıldeath 3 [☐ Ectopic p ☐ Other <i>(sp</i>		У			2	3d. Dat Mo	e of deli	very Day	Year
	ires that signed by		Part II. Other significant condition Hypertension	ons contributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I	l.					the cause	of death?
Records,	w require s been si should t	letec									24a. Was					gs available
al Re	ding Physician: The law h. After this certificate has funeral director, page 2 g	Completed by									auto		l d	rior to c leath?	ompletion o	of cause of
of Vital	siciar certif irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ v No	Hospital:		7-D/O	200	Othe	or.		h (Check only o					
of	g Phy er this eral d	n: To	27. Manner of Death	28a, Date	of Injury	ER/Outpatier		28c. Injur	y at	ursing Ho	ome 5 Resi 28d. Describe				ity)	
io	vttendin death. ctor: Aff y the fun	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	th, Day, Year)	Injury	М	Work 1 □	vr Yes 2□	No						
Division	lor Att after de Directed d in by t	Certification:	3 ☐ Suicide 6 ☐ Could determ	inod 28e, Place	of Injury - At he ng, etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory	, office			28f. Location (City or To	Street and wn, State)	1 Numbe	er or Ru	ral Route ∧	lumber,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		ng Physician: To the Examiner: On the b and man												e(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie				290	c. License	e number	//		29d. Date	a signed	(Month	, Day, Year	r)
			1 am	Sun	ev ~						7	12/	/ 2_	3/2	009	A
· W	X		30. Name and address of person	1	1 100			100 =	7300 U.	Valn	Dusen	Kd.	Ta	lare	I, MD	2010
	— () Sta	ite	31. Date filed (Month, Day, Year)	rguleres	egistrara Signa	Laure	1 Ney	ona	1 Has	DI Ta	-1, uner	yenc	Y D	الريا	1	
	Registr		31. Date filed (Month, Day, Year) BEC 3 1 2009	Beneva	p. 19											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec.28 . 20<u>09</u> Physician/ Ellen Grace Downs 9:00a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Nursing Home Williamsport Washington If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-10-5061 1 □ M 2 🛛 F 91 Months Hours (Month, Day, Year) 10-5-1918 Frederick MD **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am pring into or other traumatic event, the Medical Examiner must be nortfied once. 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD Washington Williamsport 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 154 N.Artizan Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) public school Elementary/Seconday (0-12) College (1-4 or 5+) teacher 12th grade Be 17. Father's Name (First, Middle, Last)
Ola Elroy Fink 18. Mother's Name (First, Middle, Maiden Surname) 0 Grace Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Rowe daughter 11929 Cedar Ridge Rd.Williamsport MD 21795 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $12 - 30^{\text{ate}}$ 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other place)

. Paul Cem. Clear Spring MD St. 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature Fun rai Service Lie 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 7. Enter the disease, or complications that caused ock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 2 X No 1 Yes 2 🗌 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation s after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of certifier Jecember, 29, 2009 02 30. Name and address of person who compl cause of death (Item 23a) (Type, Print) 2 Mahmood HAgersTOWN, MD 21742 280-C mp Northern Ave

State

Registrar

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Plea

ase Type or Print in Black Indelible Ink. Ensure All Copies Are I	Legible.	
State of Maryland / Department of Health and Mental Hygiene	2009	1,3058
Certificate of Death	Reg. No.	40000

			1- For State Registrar	Certificat	e of Death		Reg	. No.) 5 4 5 0 5 0
	Physici I Exam		Decedent's Name (First, Middle, Last)	Marie Davi	s		2. Date of Death Month I December 2	рау Үеаг 24, 2009	3. Time of Death 0747 hrs
			4a. Facility Name (if not institution, give street and numb Washington County Hospital	er)	4b. City, Town, o	r Location of Death	h	4c. County of Washing	
	-uneral Director		219-08-8585 1_M 2XF	Age (In yrs. last birthd	yrs. If Under 1 Ye Months Da		_		Birthplace (State or Foreign Country) Maryland
	ne Maryland or 28a-f show any fied at once.	or	Usual Residence of Decedent 10a. State 10b. County Maryland Washington	10c. City, Town or		nithsburg			10d. Inside City Limits 1 Yes 2 No
	death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e Street and Number 23234 Foxville Road		10f. Zip Code	1783	10g	, Citizen of Wha	at Country? JSA
	r death with the or items 23a must be noti	Funeral	11. Marital Status 1 Never Married 2 X Married 1 Yes		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto		White,	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade or Elementary/Secondary (0-12) College (1-4)	dur	1 Yes 2 X N cedent's Usual Occupa ring most of working lif	ation (Give kind of		Specify:	White iness/Industry
-0036	d within 72 giene. ther than	Completed	12 17. Father's Name (First, Middle, Last)		Title Cl		e (First, Middle, Ma		uto
21215	Mental Hy marked o	o Be	Donald Elmer Pitsnogle 19a Informant's Name/Relationship (Type, Print)		Mailing Address (Stre		an M. Se.		, State, Zip Code)
WD,	and 2 sho lealth and tem 27 is traumati	٢	Curtis L. Davis (Husb	20b. Place of D	34 Foxvill	emetery	Date		and 21783 City or Town, State
ltimore	permit rages I Department of F Important: If i injury or other		1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	State crematory Manor C	or other place) emetery 22. Name and Addres	3	ecember 1, 2009	Boons	sboro, Marylan
	permit Departr Import injury	_	23a. Part I. Enter the disease, or complications that caus	MO 1 4 1 4	12525 Bra	dbury Av			Maryland 21783
/1	nedical aminer		failure. List only one cause on each line.	hromboembolism					Between Onset and Death
		ner	Sequentially list conditions, b	nsequence of):					
	ited J ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a coid	nsequence of):					
Ö,	reate be executed physician and the burial - transit	Medical		7,28c,d,e	per me,g89	9,01/13/	10dhb	I a a a a a a	
Box 68760,	death ceruncatane at the dor use as the	sician/	23b. Was decedent pregnant in the past 12 months?	at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	23d. Date of d Month	Day Year
P.O.	signed by the	d by Phy	Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown
Vital Records,	has been 2 should	Completed					24a. Was an autopsy perform 1 ✓ Yes 2	ed? de	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
/ital	ysiciani: The his certificate director, page	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpa	atient 2 🗸 ER/Outpa		of Death (Check		esidence 6	Other:
on of	ath or: After t he funeral	-	27. Manner of Death 1 X Natural 5 Pending 28a. Date of I (Month. Da	njury x.Year) 28b. Tim 0000 m	_	ury at Work? Yes 2 No	28d. Describe ho	w injury occurred	d
Division	hours after de ineral Direct	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify)	FInjury - At home, farm	, street, factory, office	building, etc.	28f. Location (Str or Town, Sta	te)	or Rural Route Number, City
;	vithin 24 hr To the Fun completely	edical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of earth and manner state	xamination and/or inve	occurred at the time, o estigation, in my opinio	date and place, and n, death occurred a	d due to the cause(at the time, date an	s) and manner a d place, and du	es stated e to the cause(s)
	- > 1 5	Me	29b. Signature and title of certifier Womente Dre Youle		29c. Licen	se number .M.E.		29d Date signed December 2	d (Month, Day, Year) 25, 2009
6)		30 Name and address of person who completed cause of Margarita Korell MD. Assistant Medica		I1 Penn Street, E	Baltimore, MD	21201		-
		_	(47)	trar's Signature					-

Manokin Manor Prince		Day Year
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, Prince	or Location of Death CESSAMNE If Under 24 Hrs. 8. Date of B. Hours Min. (Month, I	4c. County of Death
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Days	02-20-	Birth 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent		10d. Inside City Limits 1 X Yes 2 □ No
11974 Edgehill Terrace 21 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cu	853 Hispanic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.)	Specify:
(Specify only highest grade completed) Specify only highest grade completed) Specify only highest grade completed Specify only highest g	e during most of working ed) erator	White 16b. Kind of Business/Industry State Highway Dept.
Tr. Father's Name (First, Middle, Last) Charlie M. Doyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street James Doyle/Son 513 South Pi	18. Mother's Name (First, Middle Bertie Mae Pri	
James Doyle/Son 513 South Pi	nehurst Ave., Sa	Lisbury, MD 21801 20c. Location - City or Town, State
4 Donation 5 Other (Specify) Beechwood Cemete 1 Service Vicensee ry 12/26/2009 ress of Facility neral Home		
Physician [Medical Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. In predict Cause (Final do ase or condition resulting in death) Due to (or as a consequence of):	erset AVE., Prin	arrest, MD 21853 Approximate Interval Between Onset and Death
per position of the property o		5ylavs.
IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 2 Environmental place of the past predname 2 Environme		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause g		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Be Completed by Secretificate has been significant page 2 should be ector, page 2 should be ector, page 2 should be ector, page 2 should be ector, page 2 should be ector, page 3 should be ector, page 3 should be ector, page 4 should be ector, page 5 should be ector, page 4 should be ector, page 4 should be ector, page 4 should be ector, page 4 should be ector, page 4 should be ector, page 4 should be ector, page 4 should be ector, page 5 should be ector, page 4 should be extended by ector, page 4 should be extended by ector, page 4 should be extended by ector, page 4 should be extended by ector, page 4 should be extended by ector, page 4 should be extended by extended by ector, page 4 should be extended by ector, page 4 should be extended by ector, page 4 should be extended by ector, pag	per 1 □ Yes	opsy prior to completion of cause of death? 2 No 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		sidence 6 Other (Specify)
28a. Date of Injury — 28b. Time of Injury —		(Street and Number or Rural Route Number, own, State)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licer	opinion, death occurred at the time	e, date and place, and due to the cause(s)
in Marine State St	No Si 359	29d. Date signed (Month, Day, Year) December 215 + 2009
State Registrar 30. Name and address of person with completed cause of death (name 23a) (type, Print) P.R. Usha Natura 1415 S. DIVISION ST, SAUS BU 31. Date filed (Month, Day, Year) 32. Registrar's Signature P.F. 23 2009 Chinese A. Aparel	RY MD 21804	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** DeShields 9:30 A.M Lettie 12 21 - 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Princess Somerset Anne 2089 College Place If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🜠 F 99 Yrs. 199-18-8679 -1910 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he provided one. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Director Somerset Anne Princess Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. A 21853 30723 Hampden Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) frivate family Home Domestic 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hall Doane Nutter Janie ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dol Field Ave, Baltimore, Md Kosalee Watkins · Daughter 3842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 □Cremation 3 □Removal from State Oaksville Md. Saint Mark's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address A Facility 21. Signature of Funeral Service Licenses Anthony E. Ward F. H. E-Wal 30639 Hampden Ave Princess Anne, md 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗖 No 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2MNo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar R. BARAL, NW

12-21-2009

Amended per fd,	#15 , 12/2	2/00 Allogany Co	•	ndelible Ink. Ensure All artment of Health and Me	_	
		For State Registrar		artificate of Death	Reg. N	2009 131151
		Decedent's Name (First, Middle, Last)		···	2. Date of Death	3. Time of Death
Physic Me	cian/ dical	EDNA J.	Deist		Month 19	2009 0954
Exan	niner	4a. Facility Name (if not institution, give stre		4b. City, Town, or Location of Death COMBERLAND If Under 1 Year If Under 24 Hrs.	>	c. County of Death ALLEGANY O Distribution (Charles of Exprise)
Funer Directo		5. Social Security Number 6. Sex 1 70 - 26 - 216 4 Usual Residence of Decedent	7. Age (In yrs. last birthday) 7. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
faryland 8a-f show irfied at	ector	10a. State 10b. County Somer	10c. City, Town or Lo	version VERSIDALE		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number	hereek Road	10f. Zip Code	10g. C	Citizen of What Country?
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21215-0036 within 72 hours after giene. er than "natural", o, the Medical Exami,	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)	completed) (Give	dent's Usual Occupation kind of work done during most of working OO NOT use retired)	9	Kind of Business Industry
4 withir ygiene ygiene the the	Be Co	8		FACTORY WORK		
Maryland 21 2 should be filed with the and Mental Hygies 27 is marked other traumatic event, the	10 B		enry Deist	LeorA	(First, Middle, Maider	Felker
e, Mar and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationship (Type,	SISTER) 441	ing Address (Street and Number or Rural 13 BRUSHCREEK	Road 1.	neyersdale, PH
⊙ 85 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)		lence PA
Baltim permit. Par Departmer Important any injury	once	21. Signature of Funeral Service Licensee M, Ray Lesku	ne 10094 1	2. Name and Address of Facility N. RAY Leckeme	by Funez	203 NEZINST al Horne Meyersdele M
Physicia Medic Examin	al	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)		ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
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Is, P.O. Lires that the n signed by t	ed by Pl	Part II. Other significant conditions contributions	buting to death but not resulting in the			o use contribute to the cause of death? 2 🖬 no 3 🗆 Probably 4 🗀 Unknown
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/ital sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	26. Place of Death (Checks)		6 ☐ Other (Specify)
of \oldsymbol{V} g Phy er this	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury		8d. Describe how inj	
Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 Hours after death. The Funeral Director: After this certificate his completed filled in by the funeral director, page	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 🖵 Yes 2 🗆 No	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A completed filled in by the fu	Medical C	(Check 2 Medical Examiner	On the basis of examination and/or inve	occured at the time, date and place, and stigation, in my opinion, death occurred at the stigation.	the time, date and pla	ce, and due to the cause(s) and manner stated.
Fo the vithin 2 Fo the comple	ž	only one) 3 Certifying Nurse P 29b. Signature and title of certifier	ractioner: To the best of my knowledge,	death occurred at the time, date and place 29c. License number		e(s) and manner as stated. Date signed (Month, Day, Year)
3		30, Name and address of person who com	/	NO D-1486T	Di	EC. 1974, 2009
_ Nd	1	Robustiano B	area W.D.	200 GLENN S	TICOUR	PLAND MD 21502
Regis	itate strar	31. Date filed (Month, Day, Year) DEC 22 2009	22. Registrar's Signature	Kel		

			Swither Jayaray D66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	695	Se:	ptember 23	, 2009
	To the Hox within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated. 29b. Signature and title of certifier 29c. License	ppinion, death occurred	at the time, date a	and place, and due to Date signed (Month, L	the cause(s)
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200	ing Physic ifter this ce ineral direc	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 27. Manner of Death 1 Notural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Worl	er: 4□ Nursing Home		6 □Other (Specify,)
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parimore	permit. Pages 1 an Department of Heali Important: if item 2 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery	1/11/2	010 Roc	Location - City or Tov	
Mar	ind 2 shou alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Samuel Davis/Father 19b. Mailing Address (Street 17112 Queen Vi				*
yland	ild be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Samuel Davis	18. Mother's Name (Fi	irst, Middle, Maid Ba11	len Surname)	
-61717	l within 72 h jiene. r than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None	ation during most of working f)	16b.	. Kind of Business/Ind None	ustry
2-0030	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heaith and Mentai Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☑ Never Married 1 ☑ Never Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ispanic Origin? (Specify an, Mexican, Puerto Ric Specify: unk	y Yes or No- an, etc.)	14. Race - America Black, White, e Specify: Unkr	tc.
	ath with the 23a or 2 ust be no	Funeral Director	106. Street and Number 10f. Zip Code 17112 Queen Victoria Court #200 208		U	Citizen of What Count	es
	he Maryla 8a-f sho etifled at	ector	Maryland Montgomery Gaithersburg			uı	nk _{□Yes 2□No}
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	cville If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	Montgomer 9. Birthple Count	ace (State or Foreign
) }	Physicia /Medic Examin	al	Samee Amir Davis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or	S er Location of Death		23, 2009 4c. County of Death	9:15 a ^M
	b #	-	1 - State Registrar Certificate of I	2.	Date of Death	2009	4 3 0 6 2 3. Time of Death
			1 _ State				

DHMH 17 Rey 1/2001

Amended #25, 29a; nls, per phy., 01/05/09, Allegany Co. Amended #4b, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 01/04/10, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 12 19:29 RITA SOPHIE DOYLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESMINSTER WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Davs 1 □ M 2**XCX** MASSACHUSETTS 026-05-8595 89 10 31 1920 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Extravired into the conflict at 1 ☐ Yes 2X No Director **EVERETT** BEDFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **IIS** 569 LEADER ROAD 15537 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates Specify 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MANUFACTURING Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EMMA HARRISON WILLIAM PAQUIN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6125 DAVIS ROAD WOODBINE, MD 21797 DONNA E. DIEHL DAUGHTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DEC 29 2009 EVERETT, PA **EVERETT CEMETERY** 22. Name and Address of Facility 21. Signature of Funeral Service Lice 22 WEST MAIN ST EVERETT PA 15537 DALLA VALLE FUNERAL SERVICE INC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumon disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** S quentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit avonon Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check on one) funeral director examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 4 hours after death.

Funeral Director: A

ely filled in by the fu 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D-200 Registrar's Signature State Registrar

09-09984	
Garnet Downing	

arnet Downing	1-	State of Maryland / Department of Health and Mel For State General Amended iteam #5, WCHD, SLICertificate of Death 1.4.10	ntai Hygiene	Reg. No. 200	9 43061
Physician/		Decedent's Name (First, Middle,Last)	2. Date of D	Death	3. Time of Death
ledical Examine		Garnet Andrew Downing, Jr. a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location		Day Year ber 22, 2009	1607 hrs
	4	Penninsula Regional Medical Center Salisbury		Wicomico	
Funeral Director	5 4 4 7	6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Year 1 Under 1 Yea	ire Min	9. Birth (MM/DD/YYYY) 9. Bir Co V P	untry)
ny	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	- 1	MD Worcester Pocomoke			1 Yes 2 No
Maryland 28a-f sh 1 at once		0e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?
ith the Maryland 13a or 28a-f sho notified at once		1519 Unionville Road 21851 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	Pricin? / Specify Ves or	U.S.A.	ican Indian, Black,
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and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Ro Commission by Firmeral Director	וכ	17. Father's Name (First, Middle, East)	ner's Name (First, Midd nstabel C		
2121: uld be fi Mental I marked c event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	lumber or Rural Route	Number, City or Town, Stat	
MD of 2 shot shift and m 27 is an animatic		Delores Downing/Wife 1519 Unionvill		comoke, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by 1		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)			
Baltimore, permit. Pages lan Department of Her Important: If ite	1	4 Donation 5 Other Specify: Trinity UMC Cem 21 Signature of Fineral Service Lindings 22. Name and Address of Fac	ility 917 W	009 Pocomo	
Ba Perra Dep Imp	1	Hennie Smith Funeral Home	Salisb	ury, MD 218	301
Physician /Medical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.		y arrest, snock, or neart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) A Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	n/Me	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecte	opic pregnancy	23d. Date of delive Month	ry Day Year
Box 6876 he death certificate the attending phy ned for use as the l	Physician/N	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown		_	
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		25. Was case referred to medical 26.Place of Dec	ath (Check only one)	res 2 No 1 🗸	Yes 2 No
Vita ysician this cer	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing Home	Residence 6 Oth	er:
ding Pt	ä	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at W 1 Yes 2		ribe how injury occurred	
Division tal or Attendi rs after death. al Director: / led in by the fi	igati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building	g, etc. 28f. Locat	ion (Street and Number or I	Rural Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	4 Homicide determined (Specify)		wn, State)	
2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and (Check only)	d place, and due to the n occurred at the time,	cause(s) and manner as st date and place, and due to	ated. the cause(s)
1 H T H T	<u>ë</u>	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.			
To the within To the comple	寇L	29b. Signature and title of certifier 29c. License number 1		29d. Date signed (A	fonth, Day, Year)
		29b. Signature and title of certifier O.C.M.E.			fonth, Day, Year)
16 to 16 to		29b. Signature and title of certifier 29c. License number 1	ber .	29d. Date signed (A	fonth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item II per spouse 6901. 3720/10 dk. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2009 **Physician** ward Lewis DaMue /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorche ambridge orchester General Haspital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 23 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 1 D M 2 □ F Hours Days Months 214-36-618 Torida **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Westical Examinar must be a fifted at 1 PYes 2 □ No Director Dorchester Mbridge 10f. Zib Code 10g. Citizen of What Country? 10e. Street and Number 21613 USA leby Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 WYes 2 No 1973 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Wyes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Black Specify: \$ 3 ☐ Widowed + ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Medical Center PSMan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UnKnown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chishalm Circle-Ports Mouth, Virginia
20c. Location - City or Town, State wards inda 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State eterans Cemetery 12/22/09 Hurlock

22. Name and Address of Facility
Henry Funeral Home, P. A

510 washington st. Cambridge, Hurlock Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MD.21613 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final allesos derolic Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner estive 4ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examine State be executed burial-transit eass and Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Rosalmordish 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy wellitu certificate Dabetes 1 ☐ Yes 2 0 No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

Edwards

505A Dutchman's Lane Easton Md 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Syed Ali

31. Date filed (Month, Day, Year,

0046024

14108

Physician
/Medica
Examine

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at agnee.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 7+ MRS

	•	For State Registrar			,	C	ertificate of			Reg. No	2003	430	100
Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										3. Time of D	
/Medic	al	LEO M • 4a. Facility Name (If not institu		RETT	mher)		4h_City, Town,	or Location of Dea		40	County of Deat		50M
Examin	er	Western Md R				w.two	Cum	perlar	nd		Allega		
uneral		5. Social Security Number	6. S		7. Age (In yrs.		Months Days	If Under 24 Hr Hours Mir	n (Mor	of Birth hth, Day, Year	·)	nplace (State or untry)	
irector		234–42–9974 Usual Residence of Decedent		X	80	Yrs.			02/0	3/1929	WES	ST´´VIRGI	LNIA
MOL W		10a. State 10b. County 10c. City, Town or Location								•	10d. Inside City		
Sa-f sl	Director	WV M	INER.	AL	F	ORT A	ASHBY					1 □ Yes	2 ½ No
corporation of result and worked of then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination in all be notified at once.	Dire	10e. Street and Number 400 LEON DRI	Æ				10f. Zip Code 26719				itizen of What Co U•S•A•	untry?	
ns 23	Funeral	11. Marital Status		12. Was Dec	edent Ever in U.	S. 1	3. Was Decedent of If Yes, specify Cul		(Specify Yes		14. Race - Ame		
or iter		1 ☐ Never Married 2 💢 N	arried	Armed For 1 X Yes If Yes, Gi	2 No		If Yes, specify Cut 1 ☐ Yes 2 🗓 No		erto Rican, e	tc.)	Black, White	e, etc.	
ural",	d by	3 ☐ Widowed 4 ☐ Divore		Year or D	ates: KORI	KOREA				105	WI	HITE	
n "nat ledics	Completed	15. Dece (Specify only hig	hest gra	de completed)		16a. De (Gi	cedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of w ed)	vorking		Kind of Business/ CLLY-SPR	-)
er tha	Com	Elementary/Secondary (0-1	2)	College (1-40r 5+)	PROD	UCTION CO	VIROL WO	RKER	TI	RE COMPA	ANY	
d oth	Be	17. Father's Name (First, Midd MELVIN H. EVI						18. Mother's N					
marke	ပ	19a. Informant's Name/Relati				10h Ms	ailing Address (Stree			Number City		in Code)	
27 is r r trau		DOROTHA EVER					P.O. BOX 6				6719	ip code)	
rothe		20a. Method of Disposition 20b. Place of Disposition (Name of page 1) 20c. Location - Ci								Location - City or	Town, State		
tant: I		4 Donation 5 Other (Specify) FORT ASHBY CEMETERY 12/12/2009 FORT A								FORT ASI	BY, WV		
Impor any in		21. Signature of Funeral Service Licerseel 22. Name and Address of Facility UPCHURCH FUNERAL HOME, INC.											
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between											yoon.
sician		shock, or heart failure. List only one cause on each line.										Onset and D	eath
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miner	-	Sequentially list conditions, Due to (or as a consequence of):											
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
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physici the bu	Medical			d									
ding g		IF FEMALE:		23c. If yes, ou	tcome of pregna	ancy					23d. Date of de	livery	
e atter d for u	Physician/	25b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Vec 2 No. 4 Pregnant at time of death 5 Other (specify)										'e ar	
d by th	Phys	9 Unknown									the course of de	ooth?	
signed I be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									robably 4 □ U		
peen	etec	- C									utopsy findings a		
te has	Completed	Sick Sinus Dyndreme 24a. Was an autopsy performed?									prior to death?	completion of ca	ause of
rtifical	Be C	25. Was case referred to med	ical					26. Place of D		Yes 2 (XIN) (only one)	to 1 □Yes	2 No	
this ce	ToE	examiner? 1 ☐ Yes 2 No	:		·	<u> </u>	tient 3 DOA				6 ☐ Other (Spe	cify)	
After funera	ion:	27. Manner of Death 1 Natural 5 □ Per	ding estigation		of Injury oth, Day, Year)	28b. Time Injur	y Wo	ıryat rk? ∐Yes 2∐ No	28d. Des	scribe how inj	ury occurred		
ector:	ifical	3 ☐ Suicide 6 ☐ Cor	uld not be ermined	e 28e. Place	of Injury - At he	ome, farm,	street, factory, office	3100 20.10			and Number or R	ural Route Numi	ber,
al Dire	Certification:	4 ☐ Homicide det		Dulid	ing, etc. (<i>Specii</i>	y) 			City	or Town, Sta	ne)		
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certi (Check only one)	fying Phoal Exam	niner: On the b	asis of examina	wledge, do	eath occurred at the r investigation, in my	time, date and pla opinion, death o	ace, and due ccurred at the	to the cause e time, dat <i>e</i> a	(s) and manner a nd place, and due	s stated. e to the cause(s))
o the	Med	29b. Signature and title of cer	ifier	and mar	iner stated.		29c. Licer	se number		29d. D	ate signed (Moni	h, Day, Year)	
7-+		Drug C	2	moll			0	12054		Dea	moen	11 200	9
N.e.		30. Name and address of per-	on who	completed cau	se of death (Iter	n 23a) (Tyr		P.	16-1	111	MD 2	1500	
) RS	10-	GKOGG C DE	10 d	103017- 32. F	Gegistrar's Signa	ture	on Dille	- can	MARIN	erup 1	MD J	1202	
Sta Registr		31. Date fled (Month, Day Ye	2009	Deneu	L 1.	par	Hed						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/23 \mathbf{P}^{M} 009 IRVIN R. FRAZIER 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORESTVILLE NURSING & REHAB FORESTVILLE PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Hours Min. 4/16/191 Country) Hilton Director 98 Head, 245-12-5815 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 12 Yes 2 No Maryland Prince George's Capito1 Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6818 Painter Terrace 20743 United States death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 K Married þ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No "natural", Specify: Completed 3 Divorced 4 Divorced **Black** Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Daniel Frazier Katie Miller 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trau <u>Jessie Frazier / Spouse</u> Painter Terrace Capitol Heights, Maryland 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🏝 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 12/30/2009 | Clinton, Maryland Resurrection 22. Name and Address of FacilityPope Funeral Homes, P.A. Signature of Funeral Service License 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate only Interval Between Onset and Death Immediate Cause (Final Enysician/ ALZHEIMER'S DISEASE ADVANCE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 1 Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an BRADYCARDIA has page 2 performed' this certificate 1 Yes 2x X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNo ဂ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 X Natural injury 5 \square Pending work death. M 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical

10 State Registrar

Bahram Pishdad MD 1328 Southern Ave. SE Washington, DC 20032 Suite 310 31. Date filed (Month, Day, ·32. Registrar's Signature : DEC 3 1 2009 arks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check

only one 29b. Signature a

tle of certifie

Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

12/28/2009

29c. License number

D51520

		Please Type o					-	•	
		1 - State Registrar	e of Marylar		artment of I rtificate of	Health and Me Death		eg. No 2 0 0 9	43068
		Decedent's Name (First, Middle, Last)					Date of Deal Month		3. Time of Death
Physic /Med		Roland Edward	Fitzpat	rick			Decemb	er 26, 200	9 7:26 p ^M
Exam	iner	4a. Facility Name (If not institution, give street and	d number)			or Location of Death		4c. County of De-	
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth							rthplace (State or Foreign
Directo		219-38-7593 ^{1፟} ፟፟ ¹	F 67	Yrs.	Months Days	Hours Min.	07/30/1	.942 M	aryland
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
Mary a-f sh	Ş	Maryland Wicomico	S	alisbu	сy				1 □Yes 2 □ No
illed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ent, I'm Middled Examiner must be notifized at	Funeral Director	10e. Street and Number			10f. Zip Code	N 1	1	0g. Citizen of What C	country?
eath w	eral	528 Senior Way	Decedent Ever in U	10 112 1	2180		cify Ves or No-	USA 14. Race - Arr	perican Indian
or item	표	11. Marital Status 12. Was 1 Arme 1 Never Married 2 Married 1 X	d Forces? 'es 2 □ No			Hispanic Origin? (Spectan, Mexican, Puerto F	Rican, etc.)	Black, Wh	
ours a	d by	3 ☑ Widowed 4 ☐ Divorced If Yes Year	, Give Marin		1 □Yes 2 🛣No				hite
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tal Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Surname)	
should be and Mental s marked o	2			T		unknown			
and 2 shealth and n 27 is n		19a. Informant's Name/Relationship (Type. Print) Joseph Woroniecki/ste	ep-son	19b. Mailir 305	926 Johns	t and Number or Rural Bon Rd., Sa	alisbur	y, MD 2180	Zip Code)) 4
is 1 ar of Hea item (20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla	(ce)	ate	20c. Location - City o	r Town, State
Pages ment of lant: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal for 4 ☑ Donation 5 ☐ Other (Specify)	on state		ifts Reg:		26/09	Hanover,	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, I'm Modeal Examinat must be notified at any nights of the provided that the modes.	NIKE.	21. Signature of Funeral Selvice Licensee	0-61	22 H	Name and Addre	ess of Facility Funeral Hor	me Prof	essional A	Association
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The late has page	Completed				<u></u>		autops perform	med? death?	,
ding Physician: The land. After this certificate his funeral director, page	Be	25. Was case referred to medical examiner? Hospital:			Total	26. Place of Death	(Check only on	e)	
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ath.	ation	2 Accident investigation	Month, Day, Year)	Injury		rk?]Yes 2□No			
or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. F	lace of Injury - At houlding, etc. (Speci	nome, farm, str	eet, factory, office	2	8f. Location (Si City or Town	treet and Number or i n, State)	Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To							
the Ho nin 24 I the Fu	ledical		manner stated.						
vith con	Σ	29b. Signature and title of certifier	$\langle n \rangle$		29c. Licens	se number	2	19d. Date signed (Mo	oth, Day, Year)
1.		30. Name and address of person who completed	cause of death (Ite	m 23a) (Type.	Print)	5761		10-41	-07
SV		Christian D. Bou	NOS, MI	0 10	6 MilF	ord st.	SALI	ShURY,1	MD 21804
S ^e Regis	tate trar	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature bu	who			, , -	nth, Day, Year) - 69 MD 2(804
ricgis	er ell	DEC 29 2009 A							

			For	State of Ma	ryland				Mental Hy	-	0000	1.00	160
			- Registrar	241		Ce	rtificate of	Death	2. Date of De	Reg. No	2009	431	כסנ
и	Physici	an	Decedent's Name (First, Middle, Last	,					Month	Day		3. Time of	
-	/Medio Examir		JAMES LEE GREENE 4a. Facility Name (If not institution, give				4b. City, Town,	or Location of Deat	12/28		County of Death	4:04	A
-3"	Lxuiiii		PRINCE GEORGE'S	HOSPITAL C	ENTE	R	CHEVERL	Y		PR	RINCE GEO	RGE"S	
	Funeral		Social Security Number 6. S		(In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs	(Month, D	ay, Year)	Coun		
	Director		579-20-9792 Usual Residence of Decedent		86	TIS.			2/7/19	923	Macor	ı City	, AL
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation				10	0d. Inside C	ity Limits
	e Mar	ctor	DC		Wa	shing	ton					1 🌠 Yes	2 🗌 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Coun	itry?	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Exercitive must be northed at	by Funeral	1841 Massachusett			140		003	- '' M - N		ted Stat		
40	ter de	Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N		5. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (9 ban, Mexican, Puer	to Rican, etc.))- 1	 Race - Americ Black, White, € 		
036	urs af	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			1⊡Yes 2M∑No	Specify:			Specify: Bla	ıck	
5-0	72 ho	Completed	15. Decedent's Ec		I	16a. Dece	dent's Usual Occi	upation e during most of wo	rkina	16b. Kir	nd of Business/Inc	dustry	
121	vithin	Idu	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use retir	ed)	9	_			
d 2	filed withi Hygiene. ther thar	ပ္ပိ	12 17. Father's Name (First, Middle, Last)	r		Cour	Ler	18. Mother's Na	me (First, Middle		of Com	merce	
Maryland 21215-0036	ld be ental ked o ic eve	To Be	Dink Greene					Mattie	, ,		,		
	2 should be a and Mental is marked o raumatic eve	-	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address (Stree	et and Number or R		per, City or	r Town, State, Zip	Code)	
	1 and 2 Health a em 27 is		James S. Greene /	Son				d Parkway	Kensing	gton,	Marylan	d 208	95
ore	Pages 1 nent of H int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo emetery, crea	sition (Name of natory or other pl	ace)	Date	20c. Loc	cation - City or To	wn, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madral Examinat must be notified at once.		4 Donation 5 □ Other (Specify)	For	t Lin					wood, Ma		<u>d</u>
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	//	(a.a>-			^{ress of Facility} Pop boro Pike					71.7
			23a. Part 1. Enter the discusse, or compands, or heart fair re. List only	V .	m on the death.						, Maryic	Approximat	te
	Physician		shock, or heart far, re. List only Immediate Cause (Final disease or condition	core cause on each line								Interval Bet Onset and	Death
	/Medical		resulting in death)	Due to (or as a			LOLKOL						
	Examiner		Sequentially list conditions,	b									
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerying Cause (Disease or injury	Due to (or as a	conseque	ence of):							
	icate be executed physician and s the burial-transit	тхап	that initiated events resulting in death) Last	cDue to (or as a	conseque	ence of):							
8760,	te be ysicial e buri	dical		d									
9	rtifica ng ph	Medi	IF FEMALE:										
Box	eath certifi attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal	death 3[☐ Ectopic pregnar	ncy		2	23d. Date of delive		Year
Ö	at the der by the a tached fe	Physician/Me	1 ☐Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5[Other (specify)				Wichia	Day	roui
σ.	that the sed by detac		Part II. Other significant conditions of	ontributing to death bu	t not resul	Iting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute to th	ne cause of	death?
rds	quires in sign	q p	END STAGE RENAL I	DISEASE , I	IALY	SIS D	EPENDENT		10	Yes 2	□ No 3 □ Prob	ably 4 🔀	Unknown
Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by	LEFT FOOT GANGREN	ΙE					24a. Was		24b. Were auto		
Ä		Com	FEEDING DYSFUNCTI	ON					auto perfe 1 □ Yes	ormed? 2 X No	death?	mpletion of d 2 □ No	ause of
/ita	Physician: The this certificate al director, pag	Be (25. Was case referred to medical examiner?						ath (Check only				
of	Physical direction	<u>2</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatier 28b. Time o	K G BON				Other (Specif	y)	
O	Attending r death. sctor: After by the funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	W	ork? □Yes 2□No	28d. Describe	now injury	y occurred		
Division	Attence or death ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hor	ne, farm, str					d Number or Rura	l Route Nun	nber,
Ö	tal or Attres after dal Direct	Certification:	4 Hornicide	building, etc.	. (Specify)	/			City or 10	wn, State)	/		
	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in h	Medical		ysician: To the best on the basis of and manner star	examinati								s)
_	To the within 2 To the comple	M	29b. Signature and title of certifier	M			29c. Licer	nse number		29d. Date	e signed (Month,	Day, Year)	
			1000	777				30564		12/	30/2009		
0	5		30. Name and address of person who					n. DC 200	17				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Î6,2009 Physician/ December 10:41 P M Cynthia Gaines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2505 Amber Orchard Court West #104 Odenton Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours 0870171935 Alabama 416-44-8756 74 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22s and any injury or other traumatic excess. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Anne Arundel Odenton 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2505 Amber Orchard Court West #104 21113 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Audrey Burns Daniel Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray F. Gaines Spouse 2505 Amber Orchard Court West # 104 Odenton, MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 12/21/2009 Crownsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June Vervice License 22. Name and Address of Facility Jack Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 month Year 5 Other (specify) Pregnant at time of death has been signed by the detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 res 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner; On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, in my opinion.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29c. License number 29b. Signature and titl 2 U Û 30. Name and address of person who completed cause of death (Item 23a) (Type

Registrar
DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

			1 - State Registrar		partment of Health a ertificate of Death		Reg. No.	43071														
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yea																			
1	/Medic Examin	al .	Virginia May Greene 4a. Fecility Name (If not institution, give street and	ber 18, 200 4c. County of Dea																		
	Examin	er	Ginger Cove Health Center Annapolis Anne Ar																			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birthda 92 yrs.	y) If Under 1 Year If Under Months Days Hours	Min. 8. Date of (Month, July)	28, 1917 Pen	nthplace (State or Foreign country) nsylvania														
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits														
	a-fah	ctor	Maryland Anne Arundel	Annap	olis			1 ☐ Yes 2X No														
	th with the 23a or 28 in be no	Funeral Director	10e. Street and Number 4203 River Crescent Dri	ve	10f. Zip Code 21401		10g. Citizen of What C															
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f ahow any injury or other treumatic event, I'm Modical Examinal main the modified at DDGs.	þ	Armed	recedent Ever in U.S. 10 Forces? es 2 No Give ur Dates:	 Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar Yes 2 No Specify: 		_															
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur ne Madical	To Be Completed	mpleted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	cedent's Usual Occupation we kind of work done during mos . DO NOT use retired) maker	st of working	16b. Kind of Busines Home	s/Industry													
<u>5</u>	Hygin other	Ö	17. Father's Name (First, Middle, Last)	- +		er's Name (First, Mic	Idle, Maiden Sumame)															
<u>Jar</u>	Menta Menta arked aric ev	ToB	Benjamin Weissbrod		Jenni	ie Vogel																
Man	and I and I ie mu		19a. Informant's Name/Relationship (Type, Print)		tiling Address (Street and Number																	
e,	1 and Health tem 27		John R. Greene / Son 20a. Method of Disposition		Edgewater Driver position (Name of rematory or other place)	ve Edgewa Date	ter, Marylar 20c. Location - City o															
ē	Pages ient of nt: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)			12-20-2009	Edgewater,	Maryland														
Balti	permit. Departm Imports any Inju		21. Signature Funeral Service		22. Name and Address of Facili	ity George P	. Kalas Fune	eral Home														
			23a art1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.																			
1	Pnysician /Medical		the ediat cause (Final disease r condition	to (or as a consequence of):	n Pneuma	onia		Onset and Death														
	Examiner		_	erebrovo	ascular	accid	ent	5 days														
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68760,	ate be hysicie the bu	Ilcal	d																			
P.O. Box 6	To the Hospital or Attending Physicien: The law requires thet the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	by Physician/Me	by Physician/Me													in the past 12 months? 1 ☐ Lin 1 ☐ Vec. 2 ☐ No.		3 DEctopic pregnancy 5 Other (specify)		23d. Date of d Month	elivery Day Year
rds, P.	quires thet in signed by uld be deta				Part II. Other significant conditions contributing to Dementia w	o death but not resulting in the			Did tobacco use contribute	to the cause of death? Probably 4 □Unknown												
Division of Vital Records,	The law re ete has bee page 2 sho	Completed				а	utopsy prior to erformed? death	autopsy findings available completion of cause of as 2 No														
Vita	yeicien: The is certificete ha director, page	Be	25. Was case referred to medical examiner? Hospital:		1	e of Death (Check of	nly one)															
ou of	ding Phye	lon: To	27. Manner of Death 1 Natural 5 Pending				ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred															
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	Hospita 24 hours Funerel etely filles	edlcal C	(Check only 2 Medical Examiner: On the		ath occurred at the time. Sale as investigation, in my opinion, dea																	
	To the To the Compl	Me	29b. Signature and title of certifier	- M	29c. License number		29d. Date signed (Mo															
			· May 12e	ey MI	0002	29571	12/18/	2009														
p/	46		Paul BiBerez	ause Peath (Item 23a) (Type 22 2	SE Defer	159 Hry	, Crofto	2009 n ND 21114														
	Sta Registr		DEC 22 2009	2. Registrar's Signature	backs																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43072 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Griggs Alice Deborah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1958 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 51 220-80-4617 Director Marvland Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Allegany Cumberland 1 🗆 Yes 2 🛣 No 10e, Street and Number 10f, Zip Code ō 10g. Citizen of What Country? Iral", or items 23a or Examiner must be Funeral USA 21502 12005 Messick Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Laborer Packaging Page 1 and 2 should be filed wit thent of Health and Mental Hygie rtant: If item 27 is marked other njury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Sills Dolores Jean Imler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Griggs / Husband 12005 Messick Road, Cumberland, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any injury or 1 X Burial 2 Cremation 3 Removal from State Vet Cem @ Rocky Gab 12/17/2009 Flintstone, MD 4 Donation 5 Other (Specify) gnature of Funeral Sayice 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Gliobla Physician/ disease or condition Omorta Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 100 g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlansit Division of Vital Records, P.O. Box 68760 5

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deurh 14, 2000 D36766

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD

28b. Time of

injury

31. Date filed (Month, DEC Registrar

Medical

27. Manner of Death

1 Natural

Accident

Suicide

5 Pending

Investigation

6 Could not be

32. Registrar's Signature

Date of injury (Month, Day, Year)

nas

Physician /Medical Examiner

Funeral Director

s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

When 27 is marked other than "natural", or items 23a or 28a-f show other tran "natural", or items 23a or 28a-f show other transmer must be notified at r items 23a or 28a-f show inner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

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Important: If Item
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Box 68760.

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Division of Vital Records,

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ĭ9, 12:45 A M December Gordon 2009 Lincoln 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mitchellville Prince Georges Collington Episcopal Life Care 5. Social Security Number 5569 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 3kM 2 □ F Months Days Hours Min 96 012-30-5595 Sept.10, 1913 New York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Funeral Director 1 ☐ Yes 2 🖾 No MDPrince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road 20721 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⅓ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No White Specify Completed by 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Educator Research Foundations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Gordon Dorothy Lerned မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Llanfair Road Ardmore, PA 19003 Hugh B. Gordon / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec.23 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2009 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License M01315 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Weeks Urosepsis Due to (or as a consequence of): Cerebrovascular Accident Years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of with Pacemaker Dysrhythmias Years Due to (or as a consequence of): Physician/Medical Dementia Years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Anemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? History of Deep Venous Thrombosis of Leg 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mu 0. D0042049 December 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Champaloux, M.D., 14314 Old Marlboro Pike, Upper Marlboro, Md. Alain G. 32. Registrar's Signature State

Registrar

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State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mark Wayne Gingrich eremb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Lanham Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F Director 220-90-5293 60 Nov. Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Maryland Prince George's Bowie 10e, Street and Number 10f. Zip Code Funeral MARK WAYNE 15702 Perkins Lane 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electrician Be G-ingrich Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Victor Gingrich Winifred Willis 19a. Informant's Name/Relationship (Type, Print) April M. Urban/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 28 1 Burial 2 T Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final NEYMONIA Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner -1010r Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examiner ANOYIC that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 g 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an After this certificate has autopsy perform Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 INO မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier

3. Time of Death 2009 4c. County of Death Prince George's 9. Birthplace (State or Foreign 10d, Inside City Limits 1 Yes 2 ☐ No 10g. Citizen of What Country? 14. Race - American Indian, Specify: White 16b. Kind of Business Industry Electrical 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13606 England Court, Laurel, MD 20708 Alexandria, Virginia Spring, MD 20901 Approximate Interval Between Onset and Death Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans 23d. Date of delivery Dav 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDVER Parkway Suite eorge State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43075 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7605 Garland Wilber Granville Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □**x**M 2 □ F Months Days Hours Min Jan 20 Director 220-34-1475 70 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Mt. Savage MD Allegany 1 □xYes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 16101 Reds Lane NW 21545 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Korea white Completed 3 Widowed 4 Noivorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the self employed MVAC Mechanic other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Dorothy L. Stafford Wilber Garland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
201 Edgewater Drive Edgewater MD 21037 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert Garland son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Temation 3 Removal from State Scarpelli Funeral Home, P. A. 12/30/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Figneral Service License 22. Name and Address of Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 2 1 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending nours after death. neral Director: A ifilled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined ظائد. In 24 hour. In 24 hour. In 24 hour. On the Funeral Decompleted fille. Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F within 2 29b. Signature and title of certifier d address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43076 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nancy Jean HARP 2009 4:35 AM ccem ber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington **Examiner** Washington County Hospital Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔯 F Months Days Hours Min. August 26, 1937 Pennsylvania 198-30-1281 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Washington Hagerstown 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 Funeral 11234 Scarlet Oak Drive U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 X Married white If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Alma May Hornbaker Frank Henry Yeager permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11234 Scarlet Oak Drive, Hagerstown, Maryland 21740 Dewitt A. Harp, Jr. - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 31 cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ^{22. Name and Address of Facility} Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Year Month Day 2 M No signed by the a d be detached f 1 ☐ Yes 2 🎝 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy page certificate 2 🗌 No 2 1 No 1 Yes ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 No မ 1 Yes 1 🛮 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funeral 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 🛮 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) in 24 hou.

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completed fille Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 62440 De, M.D.

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kalka

31. Date filed (Month, P

Washington

legistrar's Signatur

12/31/09

JOHN Healey 09-09617 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 43077 State of Maryland / Department of Health and Mental Hygiene

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, I'v. Madical Exariance, ust be notified an once.	Completed	(Special Second	fy only highes	t grade completed) College (1-4c	or 5+)	(Give life.	kind of wor DO NOT us Engin	rk done i se retired	during most o	of working					efense	
pq	e filed al Hyg I othe vent,	Be C	17. Father's Name (F	First, Middle, L	ast)		<u> </u>	2118211		18. Mother's	s Name (F	irst, Middle				CICHSE	
<u> </u>	Ment Ment arked atic e	To E	Hans C.	Hansen						Hil:	ma Ni	ebuhi	c				
Mar	12 sho h and r is m rraum	(0)	19a. Informant's Nar	me/Relationsh	ip (Type. Print)		19b. Mailir	ng Address	(Street	and Number	or Rural F	Route Num	ber, City	or Town,	State, Zij	o Code)	
e,	1 and Healt em 2		Bendt H. 20a. Method of Dispo		n Jr. Son		950	25th	St.1	WW Wasl	hingt Date	on, I	C 2	0037	City or To	own, State	
nor	ages ent of it: If it			Cremation	3 ☐ Removal from Sta		lace of Dispo emetery, crer 11cres					6/200			•		
alti	partm. F	l	21. Signature of Fun			1111.				ss of Facility]			1				
ä	Depar Depar Impor any in		Vats	11	all					y Ave.		apoli					
	Physician /Medical Examiner	er	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition, leading to immediate Cause (F the Undark)	final	Due to (or	sed the death of line. Ship has a consequence as a conse	uence of):	ter the mode	e of dyir	ng, such as ca	ardiac or n	espiratory	arrest,			Approximate Interval Bet Onset and I	ween
	eath certificate be executed attending physician and for use as the burfal-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C														
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown										⁄ear		
ds, F	w requires that the de been signed by the should be detached	ρ	Part II. Other signific	ant condition	s contributing to death	but not resu	ılting in the ur	nderlying ca	use give	en in Part I.			tobacco			he cause of d	
So	w req	Completed									_	24a. Was				ppsy findings	
. a	The law te has age 2 s	dwo			-		-					auto	opsy ormed?	Ę	orior to co death?	mpletion of ca	ause of
ital	artifica ctor, p	BeC	25. Was case referre examiner?	d to medical		-				26. Place of	of Death (C	1 □Yes Check only		0	I□Yes	2 🗆 No	
<u>5</u>	Physician: The la r this certificate had ral director, page 2	၉	1 Yes 2 N	0	Hospital: 1 ☐ Inpa	atient 2 🗆 E	ER/Outpatien	it 3 □ DO.	A Othe	or-		5 Res		6 □Oth	er (Specii	fy)	
sion o	ending Path. or: After the funera	ation:	27. Manner of Death 1 Natural 2 Accident	5 Pending investiga	tion	njury Day, Year)	28b. Time of Injury	M 28	Bc. Injury Work 1 🗀	yat ⟨? Yes 2 □ No		l. Describe	how inju	iry occurr	ed		
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	and 28e. Place of I	njury - At hor etc. <i>(Sp</i> ec <i>ify</i>	me, farm, stre	eet, factory,	office		28f.	Location City or To	(Street a	nd Numb e)	er or Rura	al Route Num.	ber,
=	ne Hospi n 24 hou ne Funer oletely fill	Medical	29a. Certifier (Check only 2 one)	Certifying Medical E	Physician: To the be- xaminer: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a vestigation,	at the tin in my o	ne, date and pinion, death	place, and occurred	due to the at the time	e cause(, date ar	s) and mand place,	anner as s and due to	stated. the cause(s)
ř	Mithii To the Company of the Company	ž	29b. Signature and ti	le/of certifier						e number			29d. D	ate signe	(Month,	Day, Year)	
			1/9		SMO			D	67	177					1	2/22/2	009
	120		30. Name and addres	s of nerson	no completed cause of	death (Item	23a) (Type, 1	Print)	7	s S.	ite	308	1	100	·h. n.	s Mo	2140
	Stat	•	31. Date filed (Month,	Day, Year)		strar's Signati		-	10					- 111	1		-1-10
	Registra	ır	Į.	DEC 23	2009	un	A. A	ack	F.								

DHMH 17 Rev 1/2001

			For State Registrar	State of Ivial yi	•	rtificate of			eg. No.	
			Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Physici		Jimmy Ray	y Holt				Month Decemb		. NA
4.	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death		4c. County of De	
			1775 St. Michael'	s Road		Woodb			Howa	
	Funeral		Social Security Number Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. E	Birthplace (State or Foreign Country)
	Director	ļ	218-76-9246	^{M 2□ F} 49	Yrs.			Sept. 1		Maryland
	put w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	sho	5								1 □Yes 2 No
	the M	ect	Maryland Howard	1	Woodb	10f. Zip Code		T 1	Og. Citizen of What	Country?
	a or	<u>ā</u>	1775 St. Michael	c Pond		217	207		3	S.A.
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantinal must be notified at	Funeral Director		2. Was Decedent Ever i	nIIS 13			necify Yes or No-		Merican Indian,
	iter d	뜶	11. Marital Status 1 □ Never Married 2 ▼ Married	Armed Forces?			Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Black, W	
38	Irs af	β	3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2√∑No If Yes, Give Year or Dates:		1 □Yes 2X□No	Specify:		Specify: W	hite
9	2 hou	Completed by	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occi	upation		16b. Kind of Busine	ss/Industry
215	in 7:	e le	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of work ed)	ang		
21	filed within Hygiene. Ither than "	Š	8		P1	umber			Plumbin	ıg
p	e file al Hy othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Surname)	
<u> a</u>	Ment Ment rrked rric e	인	Kenneth Hurley	7			Mar	y Hol	.t	
Maryland 21215-0036	Should be filed withi and Mental Hygiene. is marked other than aumatic event, Inc. M		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Stree	et and Number or Ru	ral Route Numbe	r, City or Town, Stat	e, Zip Code)
	1 and 2 Health a tem 27 is		Jan Gordon Holt -					oad, Wo	odbine, M	aryland 21797
ore	ges 1 ar it of Hea If item or other		20a. Method of Disposition	20	b. Place of Dispo cemetery, crea	sition (Name of matory or other pl	ace)	Date	20c. Location - City	or Town, State
Ĕ	nit. Pages lartment o ortant: If Injury or e.		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Jennings	Chapel	Cemetery	12/23/09	Woodbin	e, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or of		21. Signature of Funeral Service ticense		22	2. Name and Add	ress of Facility th-Willia			-
m	Dep Per Per Per Per Per Per Per Per Per Per		Movert L.	Villean	21	26401 Rf	doe Road	Damage	ue Marul	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the cause on each line.	death. Do not en	ter the mode of dy	ying, such as cardiac	or respiratory an	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition							Onset and Death
	/Medical		resulting in death)	Due to (or as a cor	sequence of):		111000110			
	Examiner		Cognesticily list conditions		ROMBRI	ARRES	MARKTON EN DILEA	5/E		Carmity
	₽ .=	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	sequence of):		, ,			
	rificate be executed ng physician and as the burial-transit	am	Cause (Disease or injury that initiated events c.		DIAS ETE	<i>'</i> 3				
0,	e exe ian a urial-		resulting in death) Last	Due to (or as a coff	isequence of):					
68760,	ate b hysic the bi	ledical	€ d							
	ing p		IF FEMALE:					*		
Вох	attending for use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3[☐ Ectopic pregnar			23d. Date of Month	delivery Day Year
0.	t the dea by the a tached fo	sici	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)				
<u>P.</u>	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/	Part II. Other significant conditions con	tributing to dooth but not	regulting in the u	ndorlying cause a	sivon in Part I	23e Did to	phacco use contribut	e to the cause of death?
S,	signe	by				, ,	iveri ii i arti.			Probably 4 Unknown
Records,	w requir been s should	Completed	KINREIN !	10000	- MAGE	Ulive				
ec	e law has b e 2 sh	eldr.						24a. Was a autop	sy prior	e autopsy findings available to completion of cause of
<u> </u>	The laste has page	S						perfor 1 ☐ Yes		h? Yes 2 □No
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?					th (Check only or	пе)	
of \	Physic this c		I Tes ZIXINO	T	2 ER/Outpatie	III 3 LI DOA			lence 6 Other (Specify)
п		ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time o	W		28d. Describe h	ow injury occurred	
sio	ne at	cati	2 Accident investigation 3 Suicide 6 Could not be				□Yes 2□No			
Division	or Attendater death	Certification: To	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, sti pec <i>ify)</i>	reet, factory, office		28f. Location (S City or Tow	street and Number o n, State)	r Rural Route Number,
	Hospital or 24 hours afte Funeral Dir stely filled in		One Contiller AVI c	Jalama To Hank San Co	the outleader of the	th comment of at at	time data as 1 of	and then to the	onuno(n) and	or as stated
	Hosp 24 ho Fune tely f	lica		ilcian: To the best of my ner: On the basis of exa						
	To the Hospital or Attuvithin 24 hours after de To the Funeral Directo completely filled in by the	Medical	29b. Signature and title of certifier	and manner stated.		29c Lice	nse number		29d. Date signed (M	Ionth, Day, Year)
	5 <u>3 5</u> 8	-	Eura /	2/1		10. 200),			
				oll	(U 00) (T	<i>Y</i>	25747		December	21, 2009
	A	1	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	rrint)	•			

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

TEC 22 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year Evah Josephine Hill December 23, 2009 7:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11613 Eagle Avenue Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 🖫 F 235-30-0103 Director 85 West Virginia 09/28/1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expension once. 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10122 Christie Road, S.E. 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barry (NMN) Smith Fannie Delcia Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra S. Christ / Daughter 11613 Eagle Avenue, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Sunset Memorial Park 12/28/2009 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final DARCOMATOUS **Physician** ALCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sels consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Residence 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) بهم D42054 December 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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vilda i eati i led		Registrar	e of Death	Reg. No.	09 4308						
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Wilda Pearl	Hedrick	2. Date of Death Month Day Year December 24, 2009	3. Time of Death 0930 hrs						
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	th 4c. County of	Death						
Funeral		215 Cecelia Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cumberland ay) If Under 1 Year If Under 24H	Allegany Irs. 8. Date of Birth(MM/DD/YYYY)	9. Birthplace (State or						
Director		220-28-7699 1 _{□M 2} XF 84	Yrs. Months Days Hours Mi	in. 12/09/1925	ForeignMaryland Country)						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits						
yland n-f show	tor	MD Allegany (Cumberland 10f. Zip Code	10g. Citizen of What	1 X Yes 2 No						
the Mai 3n or 28	Director	215 Cecelia Street	21502	US							
eath with	Funeral	1 X Never Married 2 Married Armed Forces?	3. Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puerl		American Indian, Black, etc.						
s after d	<u>S</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify:	White						
5 72 hour in "natu	15. Decedent's Education (Specify only highest grade completed) 16. Not decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16. Kind during most of working life. Do NOT use retired)										
-003(J within giene. ther tha	omo	17. Father's Name (First, Middle, Last)	Homemaker	ne (First, Middle, Maiden Surname)	me						
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Lemuel Pearl Hedri	ck Josephi	ine Rosali							
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If iten 27 is marked other thingury or other traumatic event, the Med	의	19a. Informant's Name/Relationship (Type, Print) Walter R. Hedrick / Brother P	nailing Address (Street and Number or .O. box 14, Sumter	Rural Route Number, City or Town, 37, SC 29151	State, Zip Code)						
ore, les land of Healt If item		1 Burial 2 X Cremation 3 Removal from State crematory	isposition (Name of cemetery, or other place)	Date 20c. Location - Ci							
Baltimore, permit. Pages l ar Department of Hee Important: If ite		4 Donation 5 Other Specify: / I	land Crematory 12/ 22. Name and Address of Facility	· ·	land, MD						
	THE COURTS										
Physician /Medical	23a. Part T. Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Left Hip Fracture Complicated By Hypothermia										
Examiner		or condition resulting in death) Due to (or as a consequence of):									
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Colleges in light with the cause.									
ted Insit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
be execuician and	Medical	UNPENDED AMENDED									
tox 68760, eath certificate be executed a stending physician and for use as the burial - transit	In/Me	F FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 23									
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transil	Physician/I	1 Yes 2 ✓ No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)								
that the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribut							
ords, P w requires to us been sign should be	eted !	Atherosclerotic Cardiovascular Disease			e autopsy findings available						
Division of Vital Records, ral or Attending Physician: The law requir is after death. In Director: After this certificate has been so led in by the funeral director, page 2 should be	Completed			performed? deal	r to completion of cause of th? Yes 2 No						
ician: The certificate rector, page	Bec	25. Was case referred to medical examiner? [Hospital: 4 Input 2 ER/Output	26.Place of Death (Check	only one)							
ion of Vital tending Physician: teath, tor: After this certifi the funeral director,	입	1 V Yes 2 No Patient 2 Ervoups 27. Manner of Death 28a Date of Injury 28b Time	e of Injury 28c. Injury at Work?	ng Home 5 Residence 6 CC							
Sion Attendii death.	catio	1 Natural 5 Pending Investigation Pound Dec 24, 2009 Pound On the Pound	S Tes 2 W NO	Subject fell on her back por to environmental cold							
Divis Hospital or At 24 hours after d Funeral Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, (Specify) Single Family	street, factory, office building, etc.	28f. Location (Street and Number of or Town, State) 215 Cecelia Street , Cumberlan							
8 - 5 -	Medical C	29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death of one) 2 Medical Examiner. On the basis of examination and/or investigation.									
	ĕ	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)						
4		U _ MVI_VI_	O.C.M.E.	December 26	, 2009						
			111 Penn Street, Baltimore, M	MD 21201							
Sta Registi	ite ar	31. Date filed (Megiter Day, Year) 2009 32 Registrar's Signature	arked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 49 PM Howard Jean Doris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany Lions Ctr for Rehab and Ext Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 TF 88 202-09-9569 03/21/1921 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State MD Allegany Flintstone 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12512 Pleasant Valley Road 21530 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Specify White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Family Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Eirich Pearl Mae Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Hilltop Drive, Cumberland, MD Jon A. Howard / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 12/28/2009 Cumberland, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. The rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

permit. Pages 1 and .
Department of health a.
Important: If item 27 is.
any injuy or other **Physician** /Medical Examiner Physician: The law requires that the death certificate be executed burial-trar

Examiner

Physician/Medical

\$

Be Completed

Certification: To

Medical

(Check only one)

29b. Signature and title of certifier

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ဥ

Funeral

Director

27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

1 and 2 should be filed within. Health and Mental Hygiene.

nding physician are as the burial signed by the a d be detached for After this funeral dir Hospital or Attending ours after death.

neral Director: Af

Division of Vital Records, P.O. Box 68760,

DEMIENS	TIA			1 □ Yes 2 □	No 3 Probably 4 Unknow			
				24a. Was an autopsy performed?	24b. Were autopsy findings availabl prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	1 Othor 1	ath (Check only one) Home 5 ☐ Residence 6	☐ Other (Specify)			
27:Mahner of De th 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred /			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, facto ý)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Ph	ysiclan: To the best of my kno	wledge, death occurre	ed at the time, date and plac	e, and due to the cause(s)	and manner as stated.			

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D26907

29d. Date signed (Month, Day, Year)

Registrar's Signature

To the Hospital of within 24 hours af a To the Funeral D completely filled i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09 Edward Hatter 2300 M Charles 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Regional Allegan Medical Center mbesla 9. Birthplace (State or Foreign Country) CT 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Dec 31 Director 041-28-6653 Usual Residence of Decedent 28a-f show 10b. Count 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director ****\\\\ Mineral Ridgeley 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Rt. 3 Box 27 26753 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. I Hygiene. other than "natural", If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced 1956-195B Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Island Crk. Coal Co. coal miner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Earl Hatter Delia Tillot Hatter any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 3 Box 27 Ridgeley WV 26753 ge 1 and 2 sh nt of Health a **Betty Hatter** wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rose Hill Cemetery Date 20c. Location - City or Town, State permit. Page 1 and Department of H 1 K Burial 2 Cremation 3 Removal from State 1/4/2010 MD Cumberland 4 Donation 5 Other (Specify) 21. Signature of Fune al Service License 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

ATR, AL FIBR, LLATION Approximate Interval Between Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DISEASE CORONARY ARTENY Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying rsician and burial-transit RUPTURED ABDOMINAL AURTIC ANEVRYSM Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Arriz 2009 1 Yes 2 No 3 Probably 4 Unknown Completed URETER + BLADDER 24b. Were autopsy findings available prior to completion of cause of death? CARCINOM A 24a. Was an autopsy VENOUS THROMBOSIS performe rmed? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pleasing 24 hours after death.
To the Funeral Director: After the completed filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 017456 11/2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 memorial Avenue #402 Cumberland mp 21502 mo

DHMH 17 Rev 7/2009

State Registrar

P.0

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2009 Isiminger 06:44 М Ralph Carl Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY CUMBERLAND WMHS - REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Nov 12 1 □**y**M 2 □ F Days Hours 1936 Director 218-34-4940 73 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD LaVale Allegany 1 ☐ **x**es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Park Avenue 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**o Specify. 3 Divorced 4 Divorced Specify: Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Allegany County Finance Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F pe Ralph C. Isiminger, Sr. Juanita Cook Isiminger permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
119 Park Avenue LaVale MD 21502 Ethel Isiminger wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or othe Comps Cemetery 12/29/2009 PA Hyndman 21. Signatur f Funer S io Lice see 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter a disease, or complications the Approximate Interval Between Immediate Cau (Final disease or condition Onset and Death INTERSTITIA Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on) attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant Was decedent pros... in the past 12 months? ¹ ☐ Yes 2 ☐ NO NA 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Day the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Tes 1 Inpatient 2 Pr/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pendina 1 🗌 Yes 2 🔲 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) πpleted filled in by determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QAISRANI, NOSHIN, M.D., 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 28 2009 Registrar parka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:55PM RUTH IMLER AKVADA 2009 12 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** mo ALLEGAN CENTER Comberlano GOLDEN LIVING If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 214-16-2520 1 □ M 2 😿 F 10-3-1924 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Cumberland Director MD ALLEGANY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 512 Winifred Rd 21502 USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 2 No Specify. Specify: white þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homit HOMEMAKER OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NAOMI BLANCHE EMERICK KENNELL EDWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1754 PALO ALTO RO HYNOMAN PA 15545 FLoyd Imler Jr/ Department of Health ar Important: If item 27 is any Injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State 12-18-09 HUNDMAN Comps Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 169 Clarence Harvey H. Zeigler FH. INC HYNDMAN PA 15545 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final disease or condition resulting in death) erebrovascular accident **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading Lemma 21, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examine be executed burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3

DHMH 17 Rev 1/2001

State

Registrar

MBS

10000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0 6 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43086 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 009 James Julian Jones 10:05PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Dasta Vicomico alisbur Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 H/s 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8 Date of Birth 1 X M 2 □ F Months Days Hours Min 227-32-2329 79 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21826 USA 304 Louise Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Completed Specify: Black Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Carpenter 5th Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AMES ည Page 1 and 2 should be James Jones Esther Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 310 East Elendale Ave., Apt.l-Alexandria, VA 22301 Dennis Jones/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 01/04/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Memorial Park 21. Signa ure Fineral Service Licer 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel- 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MALICE disease or ondition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2/1 No ြုင 1 🗌 Yes Other HOSPIGE 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury Natural 5 \square Pending death. 1 Yes 2 🗆 No Accident Investigation 24 hours after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifie 10058410 (Jag) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACE BULL a Huyyn U 21802 31. Date filed (Month, Day, Year) 32. Røgistrar's Signature DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 43087 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 1:05 AM 2009 Ellen M. Kina 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown,
If Under 1 Year If Under 24 Hrs. 8 Julia Manor MD 8. Date of Birth (Month, Day, Year) 11/23/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Kensington, 1 ☐ M 2XXX 83 Director 565387456 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 🎗 🛣 No Berkeley Directo Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 370 Charity Circle Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown homemaker domestic or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Raymond L. Burgdorf Carrie E. Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health ? Mike King/ 209 Regal Dr. Falling Waters, WV 25419
Date 20c Location City or Town, State son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2009 permit. Page Department o Important: If any Injury or once. Martinsburg, WV Rosedale Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. Martinsburg, WV 25404 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ♪Physician Alzheimers Dementia /Medical Due to (or as a consequence of): Examiner Depression S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit pronic Renal Failure Due to (or as a consequence of) Box 68760. Physician/Medicai use as ettending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) the o 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1□ Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 0 No 1 Inpatient 2 ER/Outpatient 3 DOA After thir 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. within 24 hours efter death.

To the Funeral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ō To the Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number Kate M Smith CRVP R128088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 Mill WH-4 31. Date filed (Month, Day, Year)

DEC 30 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G900, 2, 18, 2010, WS
State of Maryland / Department of Health and Mental Hygiene 43088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 18, Physician/ Frances Veronica Kelley 2009 11:26 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 029 129-18-6311 Days 1 M 2 XF Months Hours (Month, Day, Year) 7/20/1924 Director 85 Massachusetts Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Annapolis Maryland Anne Arundel 1 Yes 2 X No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1090 Broadview Drive 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home 12 Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oft,
any injury or other traumatic avonate. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Connolly Joseph Halloran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1571 Secretariat Dr, Annapolis, MD 21409 Bill Kelley - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/09 Lakemont Mem. Gardens Davidsonville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Mychin T. Wobert 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Stroke Physician/ disease or condition 6 hours Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension 10 years Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlyin, Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year ☐ Pregnant at time of death☐ Unknown Yes 2 No ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate I 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2XXNo Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No မ 1 Inpatient 3 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) D0025499 12/21/2009 Mr mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Ruppel, MD 1460 Ritchie Highway Arnold, Maryland 32. Ragistrar's Signature State 3 Registrar

Box 68760

P.O.

Records,

Division of Vital

09-09663	
Walter Kinsey, Sr	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 43089

/alter Kinsey, Sr	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.
Physician al Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
Jai Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral	Dorchester General Hospital Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	217–16–1975 1XM 2 F 86 Yrs. Months Days Hours Min. June 11,1923 Foreign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
E	MD Dorchester Fishing Creek 1 Yes 2 X No
h the Maryland 3a or 28a-f sh otified at once	10e. Street and Number 2535 Old House Point Road 10f. Zip Code 10g. Citizen of What Country? USA USA
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titen 27 is marked other than "natural", or items 23a or 28a-f short ranumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Compulated by 1	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 College (1-4 or 5+) Police officer 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) County government
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Re Comm	
MD 21 12 should th and Me 1.27 is mau umatic ev	Walter E. Kinsey Jr. son 2834 Hoopers Island Rd., Church Creek, MD 21622
Baltimore, l bermit. Pages I and Department of Heal Important: If item injury or other tra	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Vet. Cemetery 12/16/09 Hurlock, MD
Baltir permit. J Departm Importa injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613
ysician /Medical	23a. Paft I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Attrefoscierotic Cardiovascular Disease Due to (or as a consequence of):
jed	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C.
uted d ansit Examiner	
60, ate be executed hysician and e burial - transit	UNPENDED AMENDED
lox 687 leath certific e attending p for use as th	
rds, P.O. E requires that the dispensioned by the detached should be detached by Physical Phy	1 Yes 2 No 3 Probably 4 🗸 Unknown
Records, The law requires fircate has been signage 2 should be	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
ital Recition: The scentificate rector, page	25. Was case referred to medical examiner? Hospital: Input 2 EP/Outcations 3 DOA Other:
n of Vit ding Physic a. After this funeral dir	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
Division o to the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	2 Accident Investigation 1 Suicide 6 Could not be determined Could not be dete
To the Hospit within 24 hour To the Funers completely fill	29a Certifier
To or To or	
	O.C.M.E. December 23, 2009 30. Name and address of person who completed cause of death (Item 23a)
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	

DHMH 17 Rev 1/2001 OCME 2006 OCME

Kellum

Blanche

Genesis HealthCare the Pines

Certificate of Death

4b. City, Town, or Location of Death

Easton

2. Date of Death

Month

Dec

Dav

Year

Talbot

14. Race - American Indian,

Black, White, etc.

1:10 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 No

home

Maryland

Black

else's

unknown)

Approximate Interval Between Onset and Death

days

MONTHY

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

0

2009

4c. County of Death

USA

Specify:

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months 1 ☐ M 2 😿 F 179-22-8002 83 Director 09-12-1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Funeral Director Talbot Cordova Md 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10369 Councell Road 21625 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Some one 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ James Wilson Blanche 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10369 Councell Rd., Cordova, Md. 21625 John Kellum / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12-19-09 | Trappe, Maryland Paradise Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home ammie 426 Dover Street, Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ongestive Physician /Medical Due to (or a a consequence of): Examiner Kellum ARDIOMATHY CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed LTYPERTUN SION burial-tran Due to (or as a consequence of): Box 68760, physician arah ATHEROSCLEROSIS Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a detached f Division or Vital Records, P.O. 9 Unknown After this certificate has been signed if tuneral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 24a. Was an autopsy performer Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mapner of Death 28b. Time of 28c. Injury at Work? Naturai 5 Pending Injury Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1. Decedent's Name (First, Middle, Last)

Sarah

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

Funeral

Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only one)

29b. Signature and title of certifier

MICHALL

31. Date filed (Month, Day, Year)

ROWLLY

30. Name and address of person who completed cause

32. Registrar's Signature

of death (Item 23a) (Type, Print)

610

MA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DUTCHMANS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended #4c perMD FCHD, KS Certificate of Death 12/22/09 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 10, 2009 Robert J. Kaas 6:20 p. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death USA Frederick 16665 Old Emmitsburg Road **Emmi**tsburg 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreigr Country)
 Maryland **Funeral** 8. Date of Birth 1 **K** M 2 □ F Months Days Hours Min (Month, Day, Director 220-26-0152 80 October Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Emmitsburg 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16665 Old Emmitsburg Road 21727 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2x No Specify: White ₩Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machine operator Baltimore Brick Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Martin Kaas Bernadette Orndorf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8946 Hampton Valley Road, Emmitsburg, Maryland
21727 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sl it of Health a Donald J. Kaas, Sr. son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Anthony s 20c. Location - City or Town, State Date permit. Page Department of Important: If any injury or 1 Surial 2 ☐ Cremation 3 ☐ Removal from State injury or 12-16-2009 Emmitsburg, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or Interval Betweer Immediate Cause (Final Onset and Death Physician/ Mon disease or condition resulting in death) Mole NI Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examir attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death the. by Part/II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 2 XNo 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has I lirector, page 2 s autopsv death? 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation To the Funeral Director: / completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number To the Hospital Medical 29a. Certifier 1' Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Optifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 118 09

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signature

310 S. Seton Ave., Emmitsburg, MD21727

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Alan Carroll

31. Date filed (Month, Day, Year

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 43092 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Physician/ Month 55 AM Paul Douglas LOVINGOOD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington <u>Hagerstown</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Virginia** 7. Age (In vrs. last birthday) Funeral 8. Date of Birth // (Month, Day, 111.√ 13 1 🛛 M 2 □ F Months Days Min. Yrs. **Director** 253-84-7094 59 Julv Usual Residence of Decedent or 28a-f shov 10a. State 10h County Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Marvland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10981 Hilltop Lane 21044 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed + Divorced Year or Dates. Unknown 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) None Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked of ည Herald Hendricks Lovingood Nannie Ellen Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Ken D. Lovingood - Son 10981 Hilltop Lane, Columbia, Md. 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of I Important: If its any injury or of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 12/30/09 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home Koliel 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ water respondency disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner manning Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical thel IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 V No Other: ၉ 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pi 124 hours after death. e Funeral Director: After the leted filled in by the funera 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 63502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Frow MDQ 1760

State

Mulamencel

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009 2/26 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Items State Registrar	29d 30	of Mary per d	and / Depa Ce	of nate of	dinb Death	and M	lental Hy	giene Reg. No Z	009	43093	
	n		1. Decedent's Name (First, Middle, La	st)						Date of Dea Month	ath Day	Year	3. Time of Death	
,	Physicia /Medic		Sheila Sue L	aws						Decembe	er 13	, 2009	4:45 PM M	
	Examin		4a. Facility Name (If not institution, give		umber)		4b. City, Town, o				4c. County of Death			
*			220 Rolling				Gaithersburg					Montgom		
	Funeral Director		5. Social Security Number 228-88-9267	ex □M2 ∏ F	7. Age (In 5	yrs. last birthday) Yrs.	Months Days	Hours		8. Date of Bir (Month, Da Mar 8,	1956	Cou	place (State or Foreign intry) nington DC	
	pu *		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or Lo	nation						10d, Inside City Limits	
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	28a-	Director	MD Montgom	егу		Galti	ersburg				10a. Citize	en of What Cou		
	with sa or	Ö	220 Rolling Road					20877	7		•	USA	,	
	ms 2	Funeral	11. Marital Status	Marital Status 12. Was Decedent Ever in U					rigin? (Spe	ecify Yes or No Rican, etc.)	- 14	1. Race - Ameri		
36	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene, is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Exertination until burnatified at	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 ∐Yes If Yes, G Year or	2 XNo		if Yes, specify Cub 1 □ Yes 2 🛂 No	an, Mexic Specif		Hican, etc.)		Black, White, Specify: W	hite	
8	tural	edt	15. Decedent's E		Dales.	16a. Dece	dent's Usual Occup	oation			16b. Kind	d of Business/Ir	ndustry	
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p	al Hy Joth vent	Be (17. Father's Name (First, Middle, Last					18. Mot	her's Name	(First, Middle,	Maiden S	urname)		
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Maryland 21215-0036	is 1 and 2 should b of Health and Ment item 27 is marked other traumatic e		19a. Informant's Name/Relationship (Thoms A. Laws/spe				ng Address (Street						· · ·	
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Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 N Donation 5 ☐ Other (Speci	v)	I .	cemetery, cre	matory or other pla	ce)		vato	200. 200	audit Ony of t	omi, outo	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Emeral Service Le	Wade	nirect	or S	2. Name and Addre	omy	Board		Bal	timore	Street	
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e.	Physician	1	shock or heart failure. List only immediate Cause (Final	one cause on		11							Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to		cell can nsequence of):	ncer					-		
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	p ti	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	o (or as a cor	nsequence of):								
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	eath certific attending p for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o							2	3d. Date of deli	very	
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oro	w requir been si should I	ted	****							1 🖫	Yes 2□		obably 4 🗌 Unknown	
Records,	m 2 01	Completed								24a. Was		24b. Were aut prior to c death?	topsy findings available completion of cause of	
_	sician: The la certificate ha irector, page 2									1 □Yes	2 No	1 ☐ Yes	2 DNo	
Vital	sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital:			Ott	ner:		Check only				
ō	Phys r this ral di	i.T	1 Yes 2 No 27, Manner of Death	1	Inpatient e of Injury	2 ER/Outpatie	nt 3 L DUA	4 🗆 1		me 5 X Resi 28d. Describe		Other (Spec	zify)	
o	ding th. Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Mc	onth, Day, Yea		Wor	rk?]Yes 2[
Division of	Atter r dea ector by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ce of Injury	At home, farm, st	reet, factory, office		12.4	28f. Location (Street and	Number or Ru	ıral Route Number,	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p.	Medical (miner: On the			th occurred at the to							
	ormple	Мес	29b. Signature and title of certifier	1	unici stated.		29c. Licens	se numbe	r	dige	29d. Date	signed (Month	ı, Day, Year)	
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	10		30. Name and address of person who	completed ca	use of death	(Item 23a) (Type,	Print)	622					-	
	10	())	Manish Agrawal,			A	ter Driv	e,Sui	te 30	JU, KOCK	VIII	200 200	חרפ חרפ	
	Sta Registr		31. Date filed (Month, Day Year)	Deneral 32.	Registrar	Signatura								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pegible State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Month} 5a ™ Angela M. Lee Medical 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Burtonsville Montgomery 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F (Month, Day, 3-1-1 232-86-7881 57 Hours Country) Director West Usual Residence of Decedent show with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6009 Turabout Lane 21044 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Howard Co. Dept of Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Social Worker Social Services years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry I. Moore Mary Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Lee-Son 6009 Turabout Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-6-2010 Greenmount Balto, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East la ans 1101 Ε. North Avenue Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician tho sepso, retun disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Day Year signed by the a 9 Unknown 9 Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at hin 24 hours after death. the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) woon 12-31-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28.35 Avenue, Suite 203 Smith

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 43095 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12-21-09 4:05 P MARIE ELIZABETH LOGAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hartley Hall Nursing Home
5. Social Security Number 6. Sex 7. Ag Pocomolce, MD
If Under 1 Year I If Under 24 Hrs. Worchester Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours Min 1 □ M 2 □ F 94 Director 220-01-7012 02 - 02 - 15Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director VA New Church Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23415 31211 Chincoteague Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (2 Sewell Broughton <u> Irene_Cropper</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gwendolyn Pitts</u> 31211 Chincoteague Rd. New Church, VA <u> 23415</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation , 5 ☐ Other (Specify) Friendship U.M. Cem. 12/26/09 <u>Wattsville, VA</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accordac, VA 23301
Inter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death anai 23a. Part Enter the disease, or complications that cau / d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deat To the Funeral Director: Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖸 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 12-21-2009 and address of person who completed cause of death (Item 23a) (Type, Print) RA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #28d, per me, g952 6-2-14 SM Certificate of Death Reg. No. For State Registrar 43096 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ alter Arnold 0315 opez M 500 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours (Month, Day, Year) MAY 16, 1978 GUATEMALA Yrs. **Director** 217-63-1288 31 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No MD. PRINCE GEORGES MT. RAINIER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 BUCHANAN ST. APT. 102 20712 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 🔀 No 1 ▼ Yes 2 No Specify: GUATEMALAN Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Specify: HISPANIC Completed 3 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonce. Elementary/Seconday (0-12) College (1-4 or 5+) 11 WINDOW CLEANER EXTRA CLEAN INC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSE Τ. LOPEZ JOSEFINA AMBROCIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOPEZ/WIFE CARMEN 3300 BUCHANAN ST. APT. 102, MT. RAINIER, MD.20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GEORGE WASHINGTON CEM.12-26-2009 4 ☐ Donation 5 ☐ Other (Specify) ADELPHI, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE. RIVERDALE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last as a consequence of attending physician a for use as the burial-Physician/Medical 0 Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death signed by the a d be detached f Yes 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv-23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed as been signal to a should to . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica eral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital P 2 🗌 No Other: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Manth, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred subject ingetsed work? 1 Natural 2 Accident 5 Pending iniury alcohol and hours after death. 09 03: LALAM 2 No Investigation Could not be **Tvomited** 3 Suicide 4 Homicide 28e. Place of Irlury - A home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3300 BUCHAN ANS determined At home APT 102 HYATTSVILLE within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) D63839 2 20912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLLAUR

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

knews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43097 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Albert Lee Luffman 1:57 AM 2009 12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Coastal Hospice at the Wicomico Lake Salis bury 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 11/05/1945 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral Min. Hours 1 🗙 M 2 🗆 F 64 Director 219-46-4861 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1107 Tyler Ave. 21804 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) roofer roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Osterwalder Fred Luffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Tyler Ave., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Linda Luffman/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Salisbury Crematory 12/30/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CANCRIA MALIGNAN T LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of physician and the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 2 TNo certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Natural 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/as investigation in the cause of examination and the caus Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

6 Huston

31. Date filed (Month, Day, Year)

29

PU

32. Registrar's Signature

BOK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Murra ack DECEMBER 2009 15:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WMHS - REGIONAL MEDICAL CENTER CUMBERLAND 8. Date of Birth
(Month, Day,
May 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign **Funeral** Days 218-12-5814 1 🕅 M 2 🗆 F Maryland Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Allegany MD Cumber1and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 10201 Christie Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk police officer state government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Clarence Murray Anna Christina McMillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Case/daughter 220 Sommerville Street #413 Cumberland, MD 21502 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Servi 22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, theart failure. List only one cause on each line. Approximate Interval Between Or set and Death Immediate Cause (Final Physician/ disease or condition Se Medical resulting in death) Due to (or as a consequence) f) Examiner Sequentially list conditions, if any, loading to him a diate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an autopsy Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2-8 filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a To the Funeral D edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 only one 29b. Signature a title of certifier 29d. Date signed (Month, Day, Year) 12/27/2009 D54411

Registrar

State

30. Name and address of person v

BEVEKLY

500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502

no completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ıryland	-	artment of I <i>rtificate of</i>				giene Reg. N é	21114	4	3099	
			Decedent's Name (First, Middle, L.)	ast)					2	2. Date of Dea				Time of Death	
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7	Examin		4a. Facility Name (If not institution, g	ive street and number)	eet and number) 4b. City, Town, or Location of Dea						eath 4c. County of Death				
4			300 Poplar St. A				Frui	tland	d		W	icomic			
	Funeral Director		220-86-4501		48 (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. s Min.	B. Date of Birl (Month, Da 8/27/	th ly, <i>Y</i> ea <i>r)</i> 1961	9. E	Country)	(State or Foreign	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation		-				10d.	Inside City Limits	
	a-f sh	ctor	MD Wicor	nico	Frui	itlan	d							1 ☐ Yes 2 ☑ No	
	or 28)ire	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zip Code				10g. Cit	tizen of What	Country?		
	th wil	la	300 Poplar St.,	Apt. 301			218	26 _			U	SA			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Widton Evan	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cub 1 □Yes 2 □ No			cify Yes or No lican, etc.)		14. Race - Ar Black, Wh Specify: W	nite, etc.	ndian,	
215-0036	2 hou natura	ted	15. Decedent's	Education	- 1	16a. Deced	dent's Usual Occu	pation	aget of working	,	16b. K	and of Busines		ry	
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Ž	1 and 2 Health a em 27 is		Susan Todd / co	ousin		7406	Liberty	town	Rd., [Berlin	, MD	21811			
ore,	es 1 a of He of He ritem		20a. Method of Disposition	Пр	20b. Plac	ce of Dispo	sition (Name of natory or other pla	ace)	Da	ite	20c. L	ocation - City	or Town,	State	
Ĕ	Pages ment of ant: If its ury or o		1 ☐ Burial 2 ☐ XCremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	e Hen	lopen Cr	em.	12/24,	/2009	Fr	ankfor	d, D	E	
Baltimore	permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once.		21. Signate 1 Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death.	Do not ent	er the mode of dy	ing, such	as cardiac or	respiratory a	rrest,		Int	proximate erval Between	
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2	/Medical		resulting in death)	Due to (or as a	a consequer	nce of):									
	Examiner	Ļ.	Sequentially list conditions, if any, leading to immediate	b		÷t\.									
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68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner		d											
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 1 Unknown 1 Un									23d. Date of Month	delivery Dag	y Year		
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n C	Jing F	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day	v, Year)	8b. Time o Injury	Wo	uryat ork? ⊒Yes 2		8d. Describe	now inju	iry occurred			
Division	or Attending Physician: after death. Director: After this certification is the funeral director, it	Certification: To	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Inju	ry - At home	e, farm, str	eet, factory, office					nd Number or	Rural R	oute Number,	
ā	ital or irs afte ral Dire		4 nomicide	building, etc						City or To					
}	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier ☐ Certifying (Check only one) ☐ Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	f examinatio	edge, deat in and/or in	n occurred at the evestigation, in my	ume, date opinion,	e and place, a death occurre	and due to the	, date ar	nd place, and	due to the	e cause(s)	
_	Vithi To th	Ž	29b. Signature and title of certifier				29c. Licer					ate signed (Me			
			preli	\sim			D 63	199			12	23/20	09.		
	ET G		30. Name and address of person when VONRA	o completed cause of d	eath (Item 2	3a) (Type,	Print) Short	c Di	r. Sa	lisbu	ay,	ud.	218	04.	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 28	2009 32. Registra	ar's Signatur	9. 4	arke								

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 2:10 PM Mary Frances Meyer December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Village Washington at Robinwood Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Country) st Virginia 1 🗆 M 2 🔀 F Months Days Hours Min (Month, Day, Year, **Director** 234-38-8292 July 16 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21742 U.S.A. 19800 Tranquility Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces'
1 A Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any mijury or other traumarin. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Secretary</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Julius Thompson Mary Pascal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8297 Morningstar Ln. Waynesboro Pennsylvania 17268 Meyer / son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haven Cemetery 12/30/2009 Hagerstown, Maryland 21. Sig ture of Fun Service License 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave. Hagerstown, Maryland 2174D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Harte Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due Exami and -transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to for as a consequence of): attending physician at for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the a g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy certificate 2 No. Yes 1 Yes **Division of Vital** 25. Was case referred to medical 7950 Tal 26. Place of Death (Check only one) Be examiner? v Hospital Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this s after death.

I Director: After this
of in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f, Location (Street and Number or Rural Route Number, filled in by determined hours after City or Town, State) Hospital within 24 hours To the Funeral Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 4 Ulnu 1123815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H1+ 354 Mill Street Hagerstown Maryland 21740 Mary E. Money, MD31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month REDA MOY 7:59 P M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel ANNE ALUNDEL MEDICIAL CENTE Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, May 27 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number **Funeral** 1 □ M 2 😾 F Director 579-22-3758 88 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20733 5612 Carroll Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14, Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3

Widowed 4 □ Divorced White item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home 10th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juanita Ramsey Terrell N. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 3831 Holly Dr., Edgewater, MD 21037 Richard S. Moy, II/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 1/4/10 Arlington, Virginia Arlington Natl. Cem. 4 Dopation 5 Other (Specify) 21. Signature of Funeyal Bervice Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PROBABLE Physician/ ISCHEMIC COLITIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death has been signed by the ge 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE TO THRIVE Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N page death? 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 2 No |₽ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Ca Brothy MD 3 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MACNEMAR 12:55 AM Decembe 200 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL GLEN BURNIE Social Security Number 6. Sex . Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 88 Months 1 **x y** M 2 □ F 1/13/192 Director 218-12-9875 MD Usual Residence of Decedent show 10b. County 10a. State : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Severna Park Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral McKinsev Rd. West 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after 42-1 ☐ Yes 2 No Specify: White Specify 3 X Widowed 4 Divorced Year or Dates 68 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Officer US Army Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oscar H. McNemar Gertrude Baldwin permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Millersville RD. Millersville, MD 21108 Barbara MacNemar Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/22/2009 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition resulting in death) Medical Intarction Due to (or as a consequence of); Examine cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I performed? Yes 2 2 No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 M No Hospital 1 Inpatient Other: ျ 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person ax. aistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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2 C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 16, 2009 Theresa Ann Manuel 11:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bowie Health Care Center Prince George's Bowie 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 □ M 2 🛣 F Days March 29 Min. New Jersey 62 Director 219-48-9636 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13500 Ivy Way 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Seconday (0-12) 12 College (1-4 or 5+) School Bus Driver Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert F. Johnson Ruth Ellen Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur M. Manuel / Husband 13500 Ivy Lane Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/23/2009 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Jan f Ken 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Death Physician/ Cord Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed the burial-transi that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical Box 68760 signed by the attending place as detached for use as 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sinn Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 4No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cortifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

Andrew Dobin, MD, 4175 North Hanson, Suite 203A, Bowie, Maryland

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaa Physician 2009 Dec /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Neighbors entrev: 01 Koad ween /tune If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 □ F Months Hours Min. 15-20-269 Maryland NOV, 21 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director entreville veen 10g. Citizen of What Country? 10e. Street and Number Neighbors 215 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event the state. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas W 19a. Informant's Name/Relationship (Type. Print) e ည yer 19b. Mailing Address (Street and Number or Rural Route Number, dity or Town, State, Zip Code) Road Centreville, MD, 21617 301-Neighbors vnita 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 1 Burial 2 □ Cremation 3 □ Removal from State Sandtown Cemetery! 12/19/09 Hillsboro, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of acility 21. Signature of Funeral Service Licensee Funeral Home, Henry Funeral Hosti Cambri 510 Washington Str Cambri dge.MD,21613 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebro Vascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years hronic kidner Sequentially list conditions Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and Due to (or as a consequence of): physician a the burial-1 Box 68760, Physician/Medical requires that the death certificate attending p SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 mon 1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sh 24a Was an autopsy performed? 1 Yes 2 No The Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation ours after death.

eral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

Dutchmans Lane, Easton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weinstein

31. Date filed (Month, Day, Year)

MD

609

32. Registrar's Signature

20, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year ELINORE C MESSEDER DECEMBER 15, 2009 7:00 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 🕱 F Director 111-20-4307 91 DEC. 28, 1917 NEW YORK Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f sh Director 1 ☐ Yes 2 No MARYLAND TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or 2 Funeral 24817 SWAN ROAD 21663 UNITED STATES Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Bace - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ral", or i Examin altimore, Maryland 21215-0036 ·by 1 ☐ Yes 2 No Specify Specify: WHITE 3 XWidowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important; if item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) 12 TELEPHONE OPERATOR COMMUNICATIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARVIN ည WILSON META WILNAU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA DALY/DAUGHTER 24817 SWAN ROAD, ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cametery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DEC. 21,2009 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON ST. EASTON, MD 21 HOME, P.A. NoHN MERCEROF 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician romes ecs /Medical Examiner enterion Hears Sequentially list conditions, if any, reading to intradiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trans and Due to (or as a consequence of): Box 68760 the attending physician certificate be Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed Case provascular accident 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only o e) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Hospital or Attending** Natural 5 Pending investigation ithin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 (ROWLEY 610 DUTCHMANS MARKL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 18 2009 Registrar

Amend #1, #3 per PHY Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept. 12-22-09 KAH State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06:45 Lewis Henry Miller Month **Physician** LCW11 Her 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Baltimore None Loch Raven Rehab & Extended Care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days Hours Min. 164-20-9744 83 Director Pennsylvania 8, 1926 Dec. Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location show 10d Inside City Limits items 23a or 28a-f shov Director 1 ☐ Yes 2X No Berks PA Hamburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19526 USA 211 Beechwood Drive Funeral traumatic event, the the digal Examinative 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1XIYes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ∏Yes 27 No Specify Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Florist Floral permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any Injury or other tranmette. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Lewis Miller Mary Huntzinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Miller / daughter 211 Beechwood Dr. Hamburg, PA 19526 20b. Place of Disposition (Name of cemetery, crematory or other place)
Indiantown Gap 20a. Method of Disposition Date 20c. Location - City or Town, State 122 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/16/2009 Annville, PA 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 21. Signature of Mineral Services 22. Name and Address of Facility Beall Funeral Tome 6512 NW Crain Hwy. Bowie, MD 23a. Party. Enter the dis-shock, or heart fail use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Immediate Cause (Find disease or condition resulting in death) **Physician** End 5/2 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 🖬 No 1 ☐ Yes 2 1No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖅 🕶 🕶 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No 2 Accident investigation 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47804 12/10/2009 puier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

A.MROWIEC

31. Date filed (Month, Day, Year) UEC 22

7900

2009

32. Registrar's Signature

Loch Reven Blvd Ballinge MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 19 2009 \mathbf{P} M THOMAS CONRAD MONTS 1:56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STEVENSVILLE QUEEN ANNE'S 1003 PENNY DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 🗆 F NEW YORK FEBRUARY 8, 1942 Director 67 Yrs. 122-32-0180 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No QUEEN ANNE'S **STEVENSVILLE** MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with UNITED STATES 1003 PENNY DRIVE 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 Yes 2 XNo Specify: Yes, Give "natural", 3 🗌 Widowed 4 🗆 Divorced BLACK Year or Dates **1962–1968** Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Meany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) REAL ESTATE DEVELOPER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ THOMAS MONTS JEWEL HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 PENNY DRIVE, STEVENSVILLE, MARYLAND 21666 BARBARA A. MONTS/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State DECEMBER 23 cemetery, crematory of other place)
HURLOCK
VETERANS CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Dether (Specify) HURLOCK, MARYLAND 2009 21. Signature FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ anyma disease or condition Medical resulting in death) Due to (or as a consequent e of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) burial-t physicians the burial Physician/Medical Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 1 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funera (Month, Day, Year) ✓ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4+1 MS 30. Name and address of person who completed dayse of death (Item 23a) (Type, Print) ancer State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 43108 1 - State Registrar Amended #10c perFH FCHD KS Certificate of Death 12/23/09 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ \mathbf{P}^{M} 2009 Doris Jane Mullican December :04 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockvill Montgomery 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Country) Months Days Hours Min (Month, Day, Year, **Director** 83 212-24-4864 Maryland Usual Residence of Decedent show 10a. State 10h. County with the Maryland "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 No Damascus Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 USA 24429 Ridge Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thurston Brewer King Pomona Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Ray Mullican, husband 24429 Ridge Road, Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Damascus Methodist Cem. 12/22/09 Damascus, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home hour 1 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition Physician. Acute myelogenous leukemia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or illijury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Year Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No page death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No ၉ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending nours after death. neral Director: Af illed in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rane MD Icane' D0068178 12-18-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 9901 Medical Center Drive, Rockville, Maryland 20850 Santosh Rane, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State	State of Maryland	-			ental Hygie	ne 2009	1.3109
			Registrar	4)	Cei	rtificate of De			NA UUJ	43102
H	Physici /Medi		1. Decedent's Name <i>(First, Middle, L.</i> Virginia	Lee		Mackert		2. Date of Death Month December	Day Year 20. 2009	3. Time of Death
and the	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Loc		occember .	4c. County of Death	
april .			229 Baltimore Av	enue, Apt 1101		Cumber			Allega	any
	Funeral Director		215-26-9417	Sex 7. Age (In yrs. la 1 □ M 2 7 F 80	ast birthday) Yrs.		Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye 11/28/19	9. Birth Cou 29 Mary	place (State or Foreign Intry) Land
	and	1	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits
	Mary f sh	ţo	MD Alle	gany		Cumberland	-1			1 ⊠Yes 2 □ No
	r 28a	irec	10e. Street and Number	34113		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	th wit	alD	229 Baltimore	Avenue, Apt 11	01	2150	12		USA	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examination is the motified at once.	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	l:	Vas Decedent of Hispa f Yes, specify Cuban, M ☐ Yes 2 ☑ No S	anic Origin? (Spec Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White,	
21215-0036	hours ural",	Completed by	3 X Widowed 4 □ Divorced	Year or Dates:						hite
7	n 72 i "nat	olete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	lent's Usual Occupatior kind of work done durin OO NOT use retired)		161	b. Kind of Business/Ir	ndustry
12	withi	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Waitress			Restaura	nt
פ	othe vent,	BeC	17. Father's Name (First, Middle, Las	')		18.	. Mother's Name (First, Middle, Mai	den Surname)	
/lai	uld bu Menta arked	٦٥ E	Henry	Carl	Simmon	S	Ethel	M	ſae 0'	Brien
a	2 sho and is ma	-	19a. Informant's Name/Relationship			g Address (Street and	Number or Rural	Route Number, C	ity or Town, State, Zi	p Code)
ტ` -	and Health m 27 her tr		Michele A. Pasqu			14 Homeste				
Baltimore, Maryland	. Pages 1 tment of h tant: If ite Jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Speci	Removal from State	sition (Name of atory or other place)	Dat		c. Location - City or T	own, State	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Lie		M. 22	Name and Address of Ba	fFacility Sta Itimore,		-	
E			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the death one cause on each line.	Do not ente	er the mode of dying, su	uch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
The .	Physician /Medical		disease or condition resulting in death)	a. Smul Cel	U 4	ing (and	cer			2 months
	Examiner		Sequentially list conditions	b.	since oi).					
	ed sit	Examiner	Sequentially list conditions, it any adding to immediate cause. Enter Underlying							
	xecut and II-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):					
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89	tificate g phy as the	edical		d						
P.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of deliving Month	ery Day Year					
C,	s that gned k e deta	by PI	Part II. Other significant conditions	contributing to death but not resul-	ting in the un	derlying cause given in	Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ğ.	w require s been sig should b	edk						1 □ Yes	2 ☐ No 3 ☐ Pro	bably 4 Unknown
<u> </u>	The ate h	Completed						24a. Was an autopsy performed 1 □Yes 2	prior to co	opsy findings available impletion of cause of
S S	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital			. Place of Death (6	Check only one)		
ō	ğ ş	은	1 ☐ Yes 2 ☒No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 28b. Time of				e 6 ☐ Other (Speci	fy)
0 .	iding Phys h. After this (funeral dir	tion	Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	28c. Injury at Work? M 1 □ Yes		d. Describe how in	njury occurred	
ISI/	Atten r deal sctor; by the	ertification: T	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - At hom	ne, farm, stre		-	. Location (Stree	t and Number or Run	al Route Number.
	s afte	Cert	4 Homicide determined	building, etc. (Specify)				City or Town, S	tate)	,
	To the Hospital or Attending P within 24 hours affer death. To the Funeral Director: After the completely filled in by the funeral press.	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Ph	date and place, an on, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due t	stated. o the cause(s)			
	within Som	Σ	29b. Signature and title of certifier	feshir 1	чр	29c. License nur D0 0	mber 155325		Date signed (Month, December 2	
	nes		30. Name and address of person who Wonsock Shin,	completed cause of death (Item 2		rint)	Cumberla	ind, MD	21502	
	Sta	e	31. Date filed (Month, Day, Year)	22 Pagistraria Signatu	-			,		
	Registra		DEC 22 2009	Seven A.	parke	/				
DUL	H 17 Rev 1/20									

09-09924

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 43110 Jamal Medina 2009 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day December 21, 2009 0230 hrs **Medical Examiner** JAMAL RAHSHARD MEDINA 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Laurel Laurel Regional Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min Director 09/08/1987 213-27-7714 1X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 'n 10a, State 0b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show Laurel once. Anne Arundel MD the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be notified at 20724 USA 237 Red Clay Road, #203 238 Pages 1 and 2 should be filed within 72 hours after death with 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Widowed Divorced f Yes. Give Year Yes 2 X No specify. Specify: Black tment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural",
or other traumatic event, the Medical Examiner. à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 21215-0036 None Unemployed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Valerie Ellen Awkward Candid Medina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 237 Red Clay Road, #203, Laurel, MD 20724 Valerie Awkward — mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, 20a. Method of Disposition rematory or other place) 1 X Berial 2 Cremation Nat'l Mem. Park 12/30/09 MD Laurel, MD onation 5 Other Specif 22. Name and Address of Facility Snowden Funeral Home nature of Funeral Servi 246 N. Washington St, Rockville, MD 20850 Approximate Interval Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or co Physician Between Onset and failure. List only one cause /Medical Death Sharp Force Injuries Immediate Cause (Final dise xamine or condition resulting in dea Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit executed Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 ✔ No 3 Probably 4 Unknown ۵ Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available been autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Residence 6 Nursing Home 5 this မ 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subiect assaulted FOUND: Natural Yes 2 ✔ No Pending death. Director: Dec 21, 2009 0144 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Red Clay Rd & Rt. 198, Laurel, MD determined (Specify) Found in road 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 22, 2009 O.C.M.E. 0 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month 17) 32. Registrar's Signature State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stephen Mukasa 1:00 a.M Medical 2009 December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Funeral Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs, last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ F Months June 13, 1957 Hours Min. Director 52 Uganda 413-33-8808 Usual Residence of Decedent or 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1448 Farm Crest Way 20905 Uganda 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Economist Ugandan Agencies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Christopher K. Mukasa Katie B. Mukasa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8343 Montgomery Run Rd. Ellicott City, MD 21043 Shem M. Mukasa (brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jan." 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mukasa Family Cemetery Bombo, Uganda, Africa 2010 22. Name and Address of Facility Rapp Funeral & Cremation Service eral Service Licensee M00982 933 Gist Ave. Silver Spring, MD. USA 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiovascular Atherosc lerotic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical 26. Place of Death (Check only one) examine†? 1 ZNYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 1 Natural injury 5 Pending 2 Accident
3 Suicide 2 🗆 No Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 5 D0018429 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Phillip Drive Olney, Maryland

DHMH 17 Rev 7/2009

Registrar

18101 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 December 5:45 A.™ Rubel Mapother <u>John</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 6. Sex **Funeral** (Month, Day, Days Hours Year 1 🖾 M 2 🗆 I Kentucky Director 87 402-22-7177 Nov. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No Potomac Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 11827 Falls Road United States "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 2 □ No 1944 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced Completed 1946 Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Intelligence Analyst CIA permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rubel Edith Dillon Edward Mapother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Mapother/Wife 11827 Falls Road, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 12/24/2009 | Alexandria, Virginia ture of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AILURE disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed this certificate 1 Yes 2 No Yes Division of Vital ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 \square Yes within 24 hours after death.

To the Funeral Director: After this c completed filled in by the funeral directions. ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical National Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining hysical in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P 29b. Signature and title of certifier 29c, License number 00061096

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore,	permit. Page 1 Department of Important: If it any injury or o	ı,	21. Sk nature Funeral Service Licensee	Bounds Fun		
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	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my know only one)	or investigation, in my opinion, death occurred	at the time, date and p	lace, and due to the cause(s) and manner stated.
	To th within To th comp	~	29b. Signature and title of certifier	20c. License number	29d.	. Date signed (Month, Day, Year)
	6		Yenjamin H Mle	yer 330743		2/28/2009
	584		30. Name and address of person who completed cause of death (Item 23a)	CARROLL St. SAL	1.6	000 0100
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	Registra		DEC 29 2009 Lama B.	park		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav -hristina 2009 EM DES 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Hours Min 04/13/1946 1 M 2 X F 219-42-8483 63 Maryland Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 27322 Nanticoke Road 21804 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yho If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TXNo Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) beauty/real estate cosmotologist/agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emmitt Meland Ada Bruce Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27322 Nanticoke Rd., Salisbury, MD 21804 Newell Messick/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 12/28/09 Salisbury, MD Name and Address of Faculty Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only HEMORRHAGE Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes 2 No 1 Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O.

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The law requires that the death certificate be executed signed by the at Id be detached for has or Attending Physician: this death. after death Director: / filled in by the Hospital 24 hours a Funeral D

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Physician/Medical 2 Completed 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 🗌 Yes 2 🗆 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the property of the cause of examiners and one of the cause of examiners. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESSON

December 23 600 North Wolfe St, Baltimore, MD, 21287

KUSSELL 31. Date filed (Month, Day, Year) 050 29

29b. Signature and title

32. Registrar's Signature

Registrar

		For State Registrar	State o	f Marylan		artment of rtificate o			lental Hy	giene Reg. No.	009	43115	
		1. Decedent's Name (First, Middle	e, Last)						2. Date of De	ath Day	Year	3. Time of Death	
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/Medic Examir		4a. Facility Name (If not institution				4b. City, Town,	or Location				County of Dea		
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Director		035-18-8848	1 □ M 2 🏋 F	90	Yrs.	Months Day	s Hours	Min.	April	8 191		ode Island	
		Usual Residence of Decedent											
ylan		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits	
Mar iffed	cto	Maryland Washi	ngton		Hager	stown						1 X Yes 2 ☐ No	
h the	Director	10e. Street and Number		J		10f. Zip Code				10g. Citiz	en of What C	ountry?	
h wii	<u>a</u>	1183 Luther Dr	ive			217	40		ĺ	U	ISA		
deat	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent o	Hispanic C	Origin? (Spe	ecity Yes or No)- 1	4. Race - Am Black, Whi		
or ite	F	1 ☐ Never Married 2 ☐ Marr		2 □ No N	avy	1 ☐Yes 2 🕅 N			r tiodii, oto.)		_		
ral",	d b	3 XWidowed 4 ☐ Divorced	Year or D	ates: Wa	ave	TELIES ZAN	o opecii,	у.			Specify:	White	
72 ho	Completed		t's Education st grade completed)			dent's Usual Occ		st of worki	na	16b. Kin	d of Business	s/Industry	
thin le.	du	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	DO NOT use reti	red)						
ad w ygier ygier t, th	ပ္ပြဲ	12	0			Retail						t Store	
tal H	Be	17. Father's Name (First, Middle,	Last)				18. Moti	her's Name	(First, Middle	, Maiden S	Surname)		
Men Men arke	ျ	Thomas Bernard	Hammarlu	nd			Sv	ea Co	lleen	Dette	rburg		
and and is m		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Stre	et and Num	ber or Rura	al Route Numb	er, City or	Town, State,	Zip Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be inclined at ance.		Barbara Hodge	 Daughter 			E. Moler	Ave.						
fiter for		20a. Method of Disposition 1 □ Burial 2 【XCremation	2 Domewel from		Place of Dispo cemetery, cre	osition (Name of matory or other p	lace)	r	ate	20c. Loc	cation - City of	r Town, State	
Pag nent ant: I		4 □ Donation 5 □ Other (S		Ha	gersto	wn Crema	tory	1/2/2	010	Hage	rstown	, Maryland	
permit. Departr Importa any inju		21. Signature of Funeral Service	Licensee			2. Name and Add			nnich				
8 3 5 8		Fred L	Vestal			415 E. W	ilson	B1vd	. Hage	rstow	m, MD	21740	
		23a. Part 1. Enter the disease, or	complications that c	aused the deat	th. Do not en	ter the mode of d	ying, such a	as cardiac	or respiratory a	rrest,		Approximate Interval Between	
Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	•							Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to	(or as a nseq	O offi							18 nons	
Examiner		abolience descare 39 care											
	ē	Sequentially list conditions.											
nsit	Examine	cause. (Disease or injury											
exec n and al-tra	xa	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
icate be executed physician and the burial-transit													
ficate phy s the	edical		u										
ires that the death certific signed by the attending I d be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregna						2	3d. Date of de	elivery	
atter for L	ciar	in the past 12 months?		birth 2 Feta nant at time of		☐ Ectopic pregna ☐ Other (specify)					Month	Day Year	
the d y the ched	ysi	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unkn										
that ed b		Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the u	nderlying cause	given in Part	t I.	23e. Did	tobacco us	se contribute	to the cause of death?	
sign sign d be	db								1 🗆	Yes 2] No 3 ☐ F	Probably 4 🗖 Unknown	
w require s been si should b	ompleted								04-144		045 144	da a fadire a sallable	
: The law cate has l page 2 s	du								24a. Was		prior to death?	autopsy findings available completion of cause of	
: Th cate pag	Ö								1 □ Yes	2 No		s 2□No	
nding Physician: th. : After this certifica e funeral director, p	Be	25. Was case referred to medical examiner?						ce of Deatl	(Check only	one)			
hysithis call dir	၉	1 ☐ Yes 2 🗖 No				nt 3 🗆 DOA			me 5 ☐ Res			ecify)	
ing F	ü	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date (<i>Mon</i>	of Injury hth, Day, Year)	28b. Time of Injury	W			28d. Describe	how injury	occurred		
tendi eath. or: / the fu	cati	2 Accident investi	not be				□Yes 2[
ter d irect irect	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Place	e of Injury - At h ing, etc. <i>(Speci</i>	ome, farm, st ify)	reet, factory, offic	9			(Street and wn, State)	d Number or F	Rural Route Number,	
To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.													
tosp 4 hou une ely fi	ledical	(Check only 2 Medical	ng Physician: To the Examiner: On the b	e best of my kno pasis of examina	owiedge, deat ation and/or it	th occurred at the ovestigation, in m	time, date y opinion, d	and place, eath occur	and due to the red at the time	cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)	
the I hin 2 the F	led	one)											
To the within to the comple	Σ	29b. Signature and title of certifie	G M	-		29c. Lice	nse number			29d. Date	e signed (Mor	nun, Day, Year) 2 C. A.S.	
SA		· meinen	or way	1			183	665°			12.	30.01.	
1041		30. Name and address of person	who completed dus	se of death (Iter	m 23a) (Type	Print)		. 0				1th, Day, Year) 30.09.	
(V		MANZAR.	DSHAP	1, 36	8 new	ee str	cel-	Her	gerst	Dion	L 17.	0 21740	
Sta	ite	31. Date filed (Month, Day Year)	4 2010 32. P	gistrar's Signa	ature	hadel							
Registi	rar	0,111		San San San San San San San San San San	10. 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5:30 p.M Mildred Estelle Noren 18 /Medical December 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours 478-03-5322 Director 95 7, 1914 Missouri Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Exyminat Function and once. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location MD Talbot Easton Directo 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9587 Gulley's Cove Lane 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify. þ Specify: white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh Christian Sallie Rose ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary K. Noren daughter 9587 Gulley's Cove Lane, Easton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State H Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem. Gardens 12/23/09 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Thomas Funeral Home P.A. Cambridge. MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Demortia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed HTN. attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed certificate I 2 M No 1 ☐ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 A Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d, Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ∏No Director: / 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 11/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier ical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) D69234 21/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 CAMBRIDEE, BYRN ST, JEEVAN ERRAISLU 503

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Llypiene Amend Items 23aPt11,25,27,28a-f per me, 8899,00 Politicate of Death

Reg. No. For State Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Delettber 1²7, 2009^{ear} 11:45 am_M Nalley Richard Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bowie Prince George's Bowie Health Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** oct 27. Hours Min. 214-14-9266 1 X M 2 T F Months 1915 94 Marviand Director Usual Residence of Decedent 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director ms 23a or 28a-f s must be notified MD Prince George's Bowie 1 ¥ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 14997 Health Center Drive #253 20716 USA items י "natural", or item ledical Examiner וז Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3X Widowed 4 ☐ Divorced White Year or Dates.1942-45 the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 Steamfitter D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard S. Nalley Agnes Poula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo E. Green/Executor 14300 Gallant Fox Lane #120, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Fort Lincoln Cemetery 12/29/2009 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie Md. 20715 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear callure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ mul disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last CERTIFICAT Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown in the past 12 months? Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Left Hip Fracture 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2**X** No Certificate: 28d. Describe how injury occurred **Subject fell** Unknown M Natural 5 Pending 2 Accident 12/04/2009 Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number of Rural Route Number Center City or Town, State) 14997 Health Center 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Assisted Living Facility Bowie,MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ANIVA that

Chopra

2009

31. Date filed (*Month, Day, Year*) **DEC 22**

Annapolis

Amended #9, MLU, Per FD. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12/23/2009 Allegany, Co. State of Maryland / Department of Health and Mental Hygien [9] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1010 JICO 16 22 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WUSHIF Haserstown M5 01 TOWN C115 Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) West 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 ☐ M 2 🗷 F 2170 Yrs Director Virginia Usual Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show notified at show 1 ☐ Yes 2 No Allegany Mt. Savage Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r 14014 Mt. Savage Road 21545 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
The man of Health and Mental Hygiene.
The marked other than "natural", or items 23s with: If item a 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown Juanita Lease 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy A. Crawford / Son 112 S. Massachusetts Avenue. Cumberland. MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Department o Important: If any injury or Cumberland Crematory 12/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 1□ Yes 2□No 2□ No To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certificat 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death.

Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in TX CertifyIng The second to the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier broundla bmer lame and address of person who completed cause of death (Item 23a), (Type, Print) 14014 March Pike Harristoway Concordia CRNP

State Registrar 31. Date filed (Month, Day, Year)

DEC 23

32. Degistrar's Signature

Degistrar's Signature

			For State Registrar	State of M	laryland		artment <i>rtificate</i>			and M	ental Hyg	giene Reg. No	200	9	43119
			1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea	ath			3. Time of Death
	Physici /Medio		James William Neder								Month Decem	ber 3		ear	05:59 AM M
1	Examir		4a. Facility Name (If not institution, give	street and number	-)		4b. City, To	own, or L	ocation of	f Death		4c.	. County of	Death	
A.			Frostburg Village Nursi						rostbu	_			Allegan		
	Funeral		5. Social Security Number 6. S	ex. 7.A	ge (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	th ly, Year)	9	Cour	
	Director		217-10-6494 Usual Residence of Decedent		97	113.	ļ				May	05, 1	912	Mar	yland
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
	Mary a-fsh	ţċ	Maryland Allegar	ıy	Mo	unt Sava	age .								1 Yes 2 □ No
	or 28	Ç	10e. Street and Number 16206 C	alla Hill Road	N.W.		10f. Zip C	ode				_	tizen of Wh	at Cour	try?
	2 should be filed within 72 hours after death with the Maryland nad Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evanther must be notified at	Funeral Director					215	45-				U.S.	.A.		
	tems tems	nue	11. Marital Status	12. Was Deceden Armed Forces	?	3. 13.	Was Decede If Yes, specif	nt of Hisp y Cuban,	panic Orig , Mexican,	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	-	14. Race - Black,	Americ White, o	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 N If Yes, Give Year or Dates:	•		1 □Yes 2	No	Specify:				Specify:	99 FL 1	
21215-0036	hour stural	be	15. Decedent's Ed		-	16a. Dece	dent's Usual	Occupati	ion			16b. K	ind of Busin	Whitness/Ind	
212	in 72	Completed	(Specify only highest gra	de completed) College (1-4or	5.)	(Give life.	kind of work DO NOT use	done dui retired)	ring most	of workin	g				,
21	d with giene er tha	ĕ	12	0	3+)	metal	model n	naker				ma	nufactu	ring	
nd	e file tal Hy dothe	Be	17. Father's Name (First, Middle, Last)					1			(First, Middle,	Maiden	Surname)		
yla	Meni Meni arke	၉	George Neder						Barba	ara Lap	op				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Route Numbe	er, City o			,
	1 and 2 Health em 27 I		Bill Martin 20a. Method of Disposition	nephew	20h Bi		Poorbou				ganville	200 1	Maryla ocation - Ci		21524-
=	Pages nent of hant, if ite		1 ☐ Burial 2 🛣 Cremation 3 🗆	Removal from State	? [sition (Name natory or oth				İ				
Baltimore,	permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licep		-		nd Crema 2. Name and				r 31, 2009	Cur	nberland	1 10	faryland
Ba	permit. Page Department of Important; If any injury or once,		21. Signature of Puneral Service Liced	W)	-						rost Ave.,	Fros	tburg. N	4D 2	1532
			23 Fart 1. Enter the disease, or comp	olications that cause	ed the death	. Do not ent									Approximate
is:	Physician		shock, or heart failure. List only a Immediate Cause (Final	one cause on each	line.	Post	4	2							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a		ence of):	/								1 karas
1	Examiner			h		,									
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events	Due to (or a	s a consequ	ence of):									
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
8760,	be ex ician burial		researing in deathly Edet	Due to (or a	s a consequ	ence or):									
387	icate phys s the l	dical		.d										+	
Вох 6	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date	of delive	erv
ă	death e atte d for u	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de		☐ Ectopic pre ☐ Other <i>(sp</i> e						Montl		Day Year
P.0	tt the de by the tached	hys	g□Unknown	g □ Unknown											
S, F	es tha igned be det	by P	Part II. Other significant conditions of	•		4	, ,				23e. Did to	obacco	use contrib	ute to th	ne cause of death?
Records,	w require been significant	ed	Denutin	chons	0	promo	time 1	ver	7		1 🗆 1	Yes 2	□ No 3	☐ Prot	pably 4 Tonknown
ecc	law ri as be 2 sh	Completed	Unen								24a. Was		24b. We	re auto	psy findings available mpletion of cause of
<u>=</u>	The cate h	201									perfo	rmed?	dea	ath?	2 □No
of Vital	sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
of \	Physi this o	၉	To res Zono				nt 3 DOA		4 12 1901		ne 5 🗆 Resid			(Specil	y)
nc	Ing Affer uner	jo	27. Manner of Death ↑ Natural 5 Pending	28a. Date of In (Month, D	lay, Year)	28b. Time o Injury	M 28	c. Injury a Work?		1	8d. Describe h	how injui	ry occurred		
isi	death.	ical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		niury - At ho	me farm str			es 2 🗆 N	-	8f Location /9	Stroot ar	nd Number	or Rum	I Route Number,
Division	after Direction by	Certification:	4 ☐ Homicide determined	building, e	c. (Specify)		J.1100			City or Tov			Oi Tidic	Troute (Valleon,
	spita hours neral y filled		29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my know	wledge, deat	h occurred a	t the time	e, date an	id place, a	and due to the	cause(s	s) and man	ner as s	tated.
:	n 24 I n 24 I ne Fu pletel	Medical	(Check only 2 Medical Exan	iner: On the basis and manners		ion and/or in	vestigation, i	n my opii	nion, deat	th occurre	ed at the time,	date an	d place, an	d due to	the cause(s)
-8-	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	ž	29b. Signature and title of certifier					License r		-			ite signed (
	6						I I)21	244	~		12	1311	09	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	Fi	1 - 1	1	rgi	MIN	1 2	15	? 2
	grass		31. Date filed (Month Day Year)	M.D., 4	trar's Signat	ure	Jay,	. / .	031	1000	91	116	, 2		~~
	Sta	ιe	TANK I TONI	1 Landy	J Olyman		.11								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELSIE MARGARET NAVE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS REGIONAL MEDICAL CENTER CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/10/1919 Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🛱 F 220-10-1721 Director 90 MARYLAND Usual Residence of Decedent or 28a-f shov ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ALLEGANY CUMBERLAND 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #1 BALTIMORE STREET 21502 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) YARN INSPECTOR 12 CELANESE FIBERS CORP. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ THOMAS PARK MYRTLE (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL NAVE / HUSBAND 701 FURNACE STREET, #102, CUMBERLAND, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State M.S.V.C.-ROCKY GAP 12/29/2009 4 Donation 5 Other (Specify) FLINTSTONE, MD Signature of Funeral Service License 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P
202 GREENE STREET, CUMBE 21502 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): death certificate be executed resulting in death) Last physician a Physician/Medical Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title an who completed cause of death (Item 23a) (Type, Print) 30. Name and a ress of per 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER LYDIA LORRAINE ORT 2009 Medical 6:15 Α 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 Hours Min (Month, Day, Year) Director 82 212-24-0424 0/06/192 Maryland Usual Residence of Decedent shov with the Maryland 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Me Leal Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Cumberland Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Fourth Street 21502 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 ☐ No Specify: Completed 3 W Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Lewis Campbell Brema Sponaugle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra S. Long/ Daughter 1814 Bedford Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory 12/22/2009 Cumberland 21. Sign Jur of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, 21502 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 49 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant
Unknown Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No detached 9 Unknown P.O. ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed certificate 2 No Yes 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?

1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death. Investigation
6 Could not be within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DAVID DUNN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signatur

133225

BEL AIR, MD.

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day Year **Physician** Elizabeth Ann Perdue 01:21 A M 31 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedal BalTimor FRANKLIN Square Hospital 8. Date of Birth April 1 Day Year) 1968 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔽 F Months Days Hours 233-15-8224 41 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hyglen. Such contents of Health and Martal Hyglen. Such contents 23a or 28a-f show Important: If fem 21 a marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, Its Profess Ervin Counts or notifies a 1 □Yes 2X No Perry Hall Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19 Bellfalls Way 21236 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Technician Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Sue Sperry William Douglas Perdue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 261 Kentucky Street, Huntington, WV 25704 Anna Sue Perdue, Mother 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date Atlantic Crematory or other place) 01/06/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Funeral ervice Licensee T. Harman 22. Name and Address of Facility Reger Funeral Home, 1242 Adams Avenue, Huntington, WV 25704 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) psis **Physician** /Medical Due to (or as a consequence of): **Examiner** acute Failure Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transi TO XICIT. LITHIUM Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the a 0.0 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed certificate 1 ∐Yes 2 1NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESODO O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR Balto md 21237 DR Nadia 31. Date filed (Month, D State

DHMH 17 Rev 1/2001

Registrar

09-09148	
Cora Paris	

Cora Paris		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg_No. 2009 43 2								
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 24, 2009 3. Time of Death 2215 hrs								
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Hospital 4c. County of Death Montgomery								
Funeral Director		5. Social Security Number 073-50-4093 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 6. Sex 1 Months Days Hours Min. July 22, 1942 Foreign West Country) Africa								
daryland 28a-f show any	or	Usual Residence of Decedent 10a. State NY 10b. County Nassau 10c. City, Town or Location Hempstead 1 X Yes 2 No								
h the Maryla 3a or 28a-f	1 Director	10e. Street and Number 92 Duncan Road 10f. Zip Code 11550 10g. Citizen of What Country? United States								
fter death wi	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 12. Was Decedent Ever in U.S. 1 Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 XX No specify: 17. Yes 2 XX No specify:								
5 5 5	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pastor 16b. Kind of Business/Industry Ezekiel's House of Prayer, Inc.								
1215-0(the filed wi ental Hygie rrked other	Be	17. Father's Name (First, Middle, Last) Daniel Garnett 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Thompson								
MD 2' 12 should th and Mo 1 27 is ma umatic e	٩	19a. Informant's Name/Relationship (Type, Print) Carl Paris, Jr. / husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Duncan Road, Hempstead, NY 11550								
imore, Pages I and ment of Heal lant. If item or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Pinelawn Memorial 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/5/2009 Farmingdale, N Y								
Balt permit. Departi	Condite Estangesen									
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensiwe cardiovascular disease complicated by Approximate Interval Between Onset and Death								
Kaiiiiiei		or condition resulting in death) Due to (or as a consequence of): oxycodone intoxication Sequentially list conditions,								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
60, te be executed nysician and e burial - transit	cal Ex	d								
ox 687(eath certifical		X UNPENDED AMENDED 23a,PII,27,28a-f,permE, g899 1/15/10 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown AMENDED 23a,PII,27,28a-f,permE, g899 1/15/10 TT 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown								
P.O. B es that the d igned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent cosmetic surgery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown								
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed by	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N								
ital Recition: The sector, page	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other: Provided No. 2								
ion of Vi tending Phys eath. Ior: After this the funeral di	tion: To	1 Ves 2 No Residence 6 Other: 27. Manner of Death 1 Natural 5 Pending Investigation Fd 11/24/09 Fd 9:30 p								
286. Date of Injury 286. Injury at work? Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending Investigation 6 X Could not be determined 1 Copecify) Full 1 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in family residence 286. Describe now injury occurred unk 286. Date of Injury 286. Injury at work? 1 Yes 2 X No 286. Location (Street and Number or Ru or Town, State) 1 6 Z Location (Street and Number or Ru or Town, Sta										
To the Hosp within 24 hosp To the Fun completely	edical	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 25, 2009								
K		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Sta Registr	-	31. Date filed (Month, Day, Year). 32. Registrar's Signature								
DHMH 17 Rev 1/200										

DHMH 17 Rev 7/2009

State Registrar DEC 16 2009

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day 21, **Physician** Mildred Peterson 6:20 P M December 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Golden Living Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 01/12/1918 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 M 2 TF 214-05-4005 91 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the National Evanteur coust by notified at 1X Yes 2 □ No MD Cumberland Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21502 604 Washington Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 X Yes 2 No 1950-If Yes, Give Year or Dates: 1978 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify: Specify \$ 3 Widowed 4 Divorced 1978 White Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Internal Revenue Serv. Customer Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ε. Koegel Peterson Maria Arthur Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important; If item 27 is any injury or other traus Nancy P. Bittner / Friend 180 Oak Ridge Drive, Meyersdale, PA Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/24/2009 Cumberland, MD St. Luke's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signafure of Funeral Service Lice 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Duer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mye 2411 Physician CA /Medical Due to (or as a conse Lience of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for selectionnes off law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Physician: The certificate 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 → Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 Dec 22, 2009 ws DO0 33280 30. Name and addres of per on who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 23 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last. 2. Date of Death **Physician** 12/21/2009 ANGELA LUCILLE POWELL 11:30 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F 216-40-6974 67 02/09/1942 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It Medical Expression and 12 in 181 Les to titled at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Director MD Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1 Wachs Court 20832 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Bldg. Service Manager Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Hungerford ပ Anita Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frank A. Powell - husband 1 Wachs Court, Olney, MD 20832 Disposition (Name of crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 20b. 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 D Removal from P arklawn Mem. Park 12/29/09 Rockville, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the dise 7 e, or com-shock, or heart failur. List only cations that caused the deat o not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Yes 2X No the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \times$ Other (Specify) HOSPICE 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ·Kouatchou 12/22/2009 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Jocelyn Kouatchou Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Stati	e or iviar	ylariu		artment of I tificate of I			ientai Hy	giene Reg. Na	2009	4	3127	
ı	Physicia		Decedent's Name (First, M. VERNON MAXWE:								2. Date of De Month 23,	ath		3. 7	Time of Death	
140	Medic Examin		4a. Facility Name (if not institu		number)			4b. City, Town, c	or Locatio	n of Death	12/23	\neg	County of Deat		3:34 M	
أيصورا			Shady Grove					Rockvi					ontgame:			
	Funeral Director		5. Social Security Number 237–52–5636	6. Şex *X M 2 🗆	7. Age (h	n yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Und Hours	er 24 Hrs. Min.	8. Date of Bir Month Da 04/01	th /193	g. Bir NC	thplace (s untry)	State or Foreign	
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. Cou		1	0c. City,	Town or Loc	ation						10d. Ins	side City Limits	
	Maryli 28a-f otified	rect	MD Mont	gamery	1	Wheat	con					1 😾 Yes 2 🗆 No				
	th the	al D	10e. Street and Number	- I			-	10f. Zip Code				10g. Citizen of What Country? USA				
	ath wi	Funeral Director	3723 Ferrara		ecedent Eve	rin II Q	20906 n.U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No									
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 X 3 Widowed 4 Divor	Married Armed	Forces? es 2 X No)	If	Yes, specify Cuba	an, Mexic	an, Puerto F	lican, etc.)	Black, White	ce - A <i>m</i> erican Indian, ack, White, etc. ^{y:} Black			
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Maryland	12 should I		19a. Informant's Name/Relation					g Address (Street						Code)		
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<u>m</u>	Page 1		1 X Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Oth	ion 3 Removal fi	rom State	Gate	etery, cem Of H	ition (Name of atory or other plac [eaven	ce)	12/3	1/09		cation - City or Jer Spri	,		
Baltimore,	permit. Departr Imports any inju		21. Signal of Funeral Service Page 22. Name and Address of Facility Snowden Fur													
П			23a. Part 1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faildre. List only one cause on each line.											Appro	oximate	
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أب	Medical Examiner		resulting in death) a. Due to (or as a consequence of):													
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ğ	h certif tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of p	regnancy	/ eath 3□	Ectopic pregnanc	21/			2	3d. Date of deli	very		
). Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ P	regnant at tin nknown	ne of dear	th 5 🗌	Other (specify)					Month	Day	Year	
, F.O.	ss that igned b	<u>ا</u> ۾	Part II. Other significant cond	litions contributing t	o death but n	not resultin	ng in the un	derlying cause giv	en in Par	t I.			se contribute to			
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	Io the Hospital or Attending Physician; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 ☐ Medica	ing Physician: To the Examiner: On the	basis of exam	ination an	d/or investig	ation, in my opinio	n death o	accurred at the	e time date an	d place	and due to the co	ouedel an	nd manner stated.	
	To the comple		only one) 3 Ll Certify 29b. Signature and title of certi	ing Nurse Praction	er: to the best	t of my kn	owledge, de	ath occurred at the 29c. License	e time, da	te and place,	and due to the	cause(s)	and manner as s signed (Month,	stated.		
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	_	Ī	30. Name and address of person					nt)				/	,			
	State		Amit Kalaria 31. Date filed (Month Day Yea	9901 Med	ical (ve, Rock	vill	e, MD	20850					
	State Registra		31. Date filed (Month, Day, Year DEC 2	8 2009	Preva		ba	Made								

State Registrar Olvey Haryland 2083

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 25, 2009 **Physician** Posselt Janet Lee /Medical 0840 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Home Frostburg Allegany Date of Birth (Month, Day, Year)
Jul 23, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 □ F_X Months Hours Director 220-28-7697 78 1931 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examination ust be notified at MD Allegany Cumberland Director 1 □ Yes 2 □ No the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 3 1220 Frederick Street 21502 Completed by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∏Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 □ 🕷 Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) executive secretary Medical Society 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth S. Randalls Lucille Mitter Randalls ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Posselt 1220 Frederick Street husband Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 12/29/2009 4 ☐ Donation ∕ 15 ☐ Other (Specify) Cumberland MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Liour 108 Virginia Avenue: Cumberland, MD 21502 OBSTRUCTIVE LUNG DISEASE Physician /Medical bue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this completely filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural
Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) John 126907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 BISHOPWAISH RD. CUMBERLAND, MD 21503 M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 28** Registrar Back.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Kathy Ann Powell December 22, 2009 10:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Care Center Frostburg Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 227-70-6970 61 Director January 11, 1948 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Evandration must be notified at 1XYes 2∐No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Barnard Street 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Register Nurse nursing home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Col. Lewis Cass Street III Ann E. Wentz ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. David L. Powell husband 320 Barnard Street 21532-Maryland Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Frostburg Memorial Park December 27, 2009 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final MYDSI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 T Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) NooYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

2 E 02

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

28

29b. Signature and title of certifier

Havit Sid 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Havit Sidhu, M.A., 925 Bishop Walsh Rd., Cumberland, MD 21502 32. Registrar's Signature

29c. License number

126907

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ James W. Palmer 146 M 12 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death . Peninsuca SA11364144 NICOMION If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth Funeral 1 XM 2 □ F Months Days Hours Min (Month, Day, Year, -4-1934 **Director** 218-30-1688 Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 XYes 2 ☐ No Snow Hill MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 306 West Green Street 21863 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married should be filed within 72 hours after or and Mental Hygiene.

is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify SpecifyBlack Completed 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State Roads Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 9th Administration Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Beatrice Palmer Charles Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Sallie Palmer/Wife 306 West Green St, Snow Hill, MD 21863 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 Domation 5 Other (Specify) Cem 12-26-2009 Snow Hill. on Miss. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Salisbury, MD 21801 Funeral Home 23a. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final FIBRILLATION Onset and Death TRICULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CARDIOMYOPATHY SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine CORONAR Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte Month Day Year 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔄 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 🗌 Yes မ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural
Accident
Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. **TCheck** 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. only one) 29b. Signature 29c. License number 705 2 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

Registrar

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SAWBURY MQ 21804

			1 - For State Registrar	State of Ma	aryland				lealth an Death	d Ment		iene	009	431	32
			1. Decedent's Name (First, Middle, Last,								ate of Deat	h Day	Year	3. Time o	
4	Physici /Medic		Minnie Parker							1	2	21	2009	2120	рм
*	Examin	-	4a. Facility Name (If not institution, give 1402 Free Rang	e Circle			Sali	sbu				Wic	County of Death		
	Funeral Director		5. Social Security Number 6. Sec 219-34-2992	7. Ago	e (In yrs. la	st birthday) Yrs.	If Unde Months	Days		Min. (A	ate of Birth Jonth, Day, -7-19	Year)	9. Birth Con MD	nplace (State untry)	or Foreign
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation							10d. Inside C	ity Limits
	Aaryli Peho	ō				isbur								1 ☐ Yes	2X No
	289-	rect	MD Wicomico 10e. Street and Number		Sar.	LSDUL		p Code			1	0g. Citiz	zen of What Cor	untry?	
	3a or	ā	1402 Free Range	Circle			218	304			TI.	.s.	A .		
	death	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	i. 13.	Was Dece	dent of H	ispanic Origin' an, Mexican, P	? (Specify)	res or No-		14. Race - Amer Black, White		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show early injury or other traumatic event, Ite Medical Examination Intelligial at anneal and once.	ρ	1 □ Never Married 2 □ Married 3 █ Widowed 4 □ Divorced	1 ☐ Yes 2 🕍 N If Yes, Give Year or Dates:	No	-	1 ☐ Yes		Specify:	derito riloar	, 610.7	F	Specify: 31ack	, 616.	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation completed)		16a. Dece	dent's Usu	al Occup	ation during most of	f working		16b. Kir	nd of Business/I	ndustry	
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2	should bd Me mark matk	Į.	Unknown 19a. Informant's Name/Relationship (7)	pe, Print)		19b. Maili	ng Addres	s (Street				r, City or	Town, State, Z	ip Code)	
Z	nd 2 state at the		Madeline Madline Waters		r								isbury		4
Baltimore,	is 1 a of Hei		20a. Method of Disposition		20b. Pla	ace of Dispo metery, crei	osition (Na	me of other place	ce)	Date		20c. Lo	cation - City or	Town, State	
Ē	Page nent c ant: If		1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State		vary	-			-29-2	2009	Iro	nshire	, MD	
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8760,	death certificate be executed be extending physicien and idea to the burial-transit and in the principle of the control of the	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	в солваци	ence of):									
.O. Box 68	death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month			ivery Day	Year		
Δ.	S G B	þ	Part II. Other significant conditions co	ntributing to death b	ut not resu	iting in the u	inderlying	cause giv	en in Part I.		23e. Did to 1 □ Y		ise contribute to XNo 3 □ Pr	the cause of obably 4	
Division of Vital Records,	e law has b	Completed									24a. Was a autop: perfor 1 □ Yes		24b. Were au prior to death?	completion of	s available cause of
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<u>_</u>	Q 55 Y	10	examiner? 1 ☐ Yes 2 No	lospital: 1 Inpatie		ER/Outpatie	nt 3 🗆 🗅	OA Ott	er: 4 ☐ Nursi	ing Home	5 Resid	епсе (6 □Other (Spe	cify)	
o uc			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury		28c. Injui Woi			Describe h	ow injur	y occurred		
)ivisio	l or Attending after death. Director: Aftel I in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	me, farm, st	M reet, facto		Yes 2 □ No	28f. L	ocation (S City or Tow		d Number or Ru	ural Route Nu	mber,
	papital hours unerel y filled	edical Ce	29a. Certifier 12. Certifying Phy (Check only one) 2 Medical Exam	sician: To the best ner: On the basis o and manner st	f examinati										(s)
	To the Ho within 24 To the Fu	Med	29b. Signature and title of certifier	und mainler st			25	c. Licens	se number			29d. Dat	te signed (Mont	h, Day, Year)	
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	2 mp		30. Name and address of person who	ompleted cause of d	leath (Item	23a) (Type.		20	001	014		- 6 (cola		
5	, , , ,		Dr. James Cocket	1346	5.1	Divis	ion.	54. :	Ste 10:	3,5	alish	معه	y mo	218	104
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	back	1	,							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Charles Franklin Ridenour /Medical December 28, 2009 04:40 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Williamsport Nursing Home Williamsport Washington If Under 1 Year | If 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**★**M 2□F Director 93 220-16-2860 Oct. 26, 1916 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show 28a-f sh Directo 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re-215 U.S.A. Ε. Magnolia Ave. permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Indical Evant net must applicate the pages. Funeral 21742 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Τ. Elmer Ridenour Cor<u>a</u> Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Ridenour/daughter 215 Magnolia Ave. Hagerstown Maryland 21742 Brenda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 1 /6/2010 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. HAgerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Se pentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as t attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant In the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ģ Month Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to Division of Vital Records, P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 No certificate I or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Il Director: A 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
Completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier KK Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0063233 ause of death (Item 23a) (Type, Print) Northern Ave, Hagerstown Mahmaad 280.C WP 31. Date filed (Month, Day, Year) egistrar's Signature State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Legible.	00 1010
State of Maryland / Department of Health and Mental H	ygiene 20	09 4313
Certificate of Death	Reg. No.	
Normal Middle Land	2 Date of Dooth	2. Time of Dooth

		1- For State Registrar	Certificate	of Death	R	eg. No.	
Physici		Decedent's Name (First, Middle,Last)			2. Date of Dea	th	3. Time of Death
Medical Exam	ner	James Arthur Reid				r 30, 2009	0901 hrs
		4a. Facility Name (if not institution, give street and num	ber)	4b. City, Town, or Location of	f Death	4c. County of Dea	th
		Union Memorial Hospital		Baltimore			
Funeral		5. Social Security Number 6. Sex 7.	. Age (In yrs, last birthday)	If Under 1 Year If Under Months Days Hours	Min	th(MM/DD/YYYY) 9. B Fore	eign
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MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	ျ	19a. Informant's Name/Relationship (Type, Print)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:30 AM. Kayfield 2009 12 16 Lane Myrtle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Pocomoke Worcester cit Drive, Ap+, 2 Lynn haven If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 💢 F 86 218-16-5240 2 /26/23 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show e notified at 1 X Yes 2 □ No Crisfield Director Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or pe U.S.A. ms 23a c 21817 406 Charlotte Funeral items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married ö 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black ծ 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) MRS. Pauls WORKEr 11 th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Dennis Lane (arol ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , Apt 2, Pocomoke city, md. 21851 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is 906 De. Augusta Rayfield - Daughter Lynn haven 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Marion Station 12/26/09 mol. Lbewezer u.mc. Cemeter 4 Donation 5 Dother (Specify) 22. Name and Address of facility Anthony E. Ward F. H. 21. Signature A Funeral Service Licensee any in 9. Wal Hampolen Ave, Princess Anne Md 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1☐Yes 2☐No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No certificate has autopsy performed' 1∐ Yes 2000 or Attending Physician; 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XVatural s after dean. 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10062172 MI)

DHMH 17 Rev 1/2001

State Registrar SHARAD

R

31. Date filed (Month, Day, Year)

MO 1604 MARKET ST. POCOMOKE CITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SATYAL,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Susan Marie Rice December 2009 Medical 3:00p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy
If Under 1 Year If Under 24 Hrs. Frederick Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F Hours Min. **Director** <u>578-58-8721</u> 63 Washington D.C. Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Frederick Maryland <u>Frederick</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1746 Wheyfield Drive 21701 U<mark>nited States</mark> death \ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Research/ Development other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Abbott Joan Janizezk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Rice/ Son <u>746 Wheyfield Drive, Frederick, Marvland 21701</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Dec.23,2009 Washington D. C. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Stauffer Funeral 1621 Opossumtown Homes P Pike, F Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) cell lung Small carcinoma One month Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy death? certificate ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) (ē 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

Sebastien Kairouz MD 46 B Thomas Johnson Drive, Frederick, Maryland 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0067931

December 21,

		For State Registrar	State	of Marylan		artment of H ctificate of L		Mental Hy	giene Reg. N2 0	09	43137
		Decedent's Name (First, Middle,	Last)					2. Date of De	eath	Vasu	3. Time of Death
Physic /Med		Constar	ice St	ewart				Dec.	18, 20	09	7:00 P M
Exam		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, Town, or	Location of Death		4c. Count	ty of Death	h
<u> </u>		Pineview Rehabi					linton				George's
Funera			6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	Cot	hplace (State or Foreign untry)
Directo	r	158-22-4935 Usual Residence of Decedent		79	113.			May 30	, 1930	We	st Virginia
/land row		10a. State 10b. County		10c. Cit	y, Town or Loc	cation					10d. Inside City Limits
Mar.	tor	Maryland Prince	George'	s		Clinton					1 √ Yes 2 □ No
th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Col	untry?
tth wil		9106 Pine Vi	ew Lane				735				States
r dea	Funeral	11. Marital Status	Armed F		.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Si in, Mexican, Puerto	pecify Yes or No o Rican, etc.)	o- 14. Ra Bla	ace - Amer ack, White	rican Indian, e, etc.
s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	If Yes, G	2 XNo ive	1	I∐Yes 2⊠No	Specify:		Spec	ify: B1a	ick
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in 72 in 72 in ma	plet	(Specify only highest	grade completed	· · · · · · · · · · · · · · · · · · ·	I (Give	kind of work done of OO NOT use retired	furina most of worl	king			,
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al Hy rothe	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	ne (First, Middle	, Maiden Surna	ıme)	
Ment Ment arked	ြို			unknow					hington		
partillior e, Ivial yiallor 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Modical Examinar ment to required		19a. Informant's Name/Relationsh									Zip Code) 20902
and and lealth	1	Kim Stewart/Da	ughter	Took		1 Inwood		# 320 Date	Silver	Sprir	ng, MD
er of		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation	3 ☐ Removal from	State	cemetery, cren	sition (Name of natory or other plac	i	uary 1,	200. Location	- City of	rown, State
it. Pa rrtmer rrtant		4 □ Donation 5 □ Other (Sp			Lee's	Cremato: . Name and Addres		010	C1:	inton	, Maryland
permit. Pages 1 Department of H Important: If ite		21. Signature of Funeral Service L	ICERSON	1480		. 001 Benn					20019
		23a. Part 1 Exter the dise se, or o	complications that	caused the deat							Approximate
Dhysisis		shock, or heart failure. List of Immediate Cause (Final	nly one cause on	each line.							Interval Between Onset and Death
Physiciar /Medica	•	disease or condition resulting in death)	a	onic Kid		.ease					1 week
Examine	1		The same of the sa	ertensio							20 vears
±, q	ie e	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	or as a conse	uence of						,
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	/						\longrightarrow	
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icate phys	dical		d								
leath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna					23d. D	ate of deli	ivery
death e atte d for	hysician/Me	in the past 12 months? 1 □ Yes 2 ☒ No	4 Pre	birth 2 Feta gnant at time of c		Ectopic pregnanc Other (specify)	y 		N	/ionth	Day Year
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The It The icate									ormed? 2 🙀 No	death? 1 ☐ Yes	2 □ No
vitai no rsician: The la s certificate ha lirector, page 2	Be	25. Was case referred to medical examiner?	Hospital:			oth	26. Place of Dea				
ding Phys th. After this funeral di	먇	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	28b. Time of	28c. Injur	y at		how injury occu		city)
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To the Hospital or Attending Physician: The law requires that the death certification 24 hours after again. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		xaminer: On the			h occurred at the tir vestigation, in my o					
To the within 2 To the comple	Me	29b. Signature and title of certifier	2)		29c. Licens	e number		29d. Date sign	ned (Monti	h, Day, Year)
		1	1	5	$\neg f$	D-24	535		Decembe	r 28,	, 2009
124		30. Name and address of person v					C-101 C	linton	Marvla	nd ⁹	20735
	tate	31. Date filed (Month, Day, Year) QEC 3 1 2009		Registrar's Sign		C. Duite	0 101 0	LINCOILS	Harytai	.10 Z	.0:93
Regis	urali	SEO O T FOOD	renous	17. 19							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** December 27, 2009 Henry A Spencer 11:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHEVERLY PRINCE GEORGE"S HOSPITAL CENTER PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XX M 2 □ F 579-64-2839 Director 62 10/14/1947 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at show 1 XYes 2 No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 1130 46th Place SE 20019 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u> Stock_Clerk</u> <u>Private</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry L. Spencer Elizabeth A. Spencer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Spencer / Mother 1130 46th Place SE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2010 Brentwood, Maryland Fort Lincoln 21. Signatur Funeral Service License 22. Name and Address of Facilit Pope Funeral Homes, P.A. are 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Squamous Cell Head and Neck Cancer Not Stated disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 √2 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1□ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 🔯 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD33255 December 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAMC 50 Irving Street NW, Washington, D.C. 20422 31. Date filed (Month, Day, Year) State **DEC 3 1 2009** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24, 2009 James Smith 11:15 P.™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 42**1**5 - 23rd Parkway Prince George's Temple Hills Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 💢 M 2 🗆 F Months Days PO 05/10/1949 **Director** 577-66-9904 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42**1**5 – 23rd Parkway 20748 AZU death \ 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ş within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hyglene. Important If Item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 15 Warehouse Manager Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Smith, Sr. Maggie Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - 23rd Parkway, Temple Hills, MD 20748 Constance L. Smith/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/30/2009 | Landover, MD 21. Sign there of Funeral Service Licer 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd-, Camp Springs, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatuc WON disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year Linknown g 🗌 Unknown Records, P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗙 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA \square Nursing Home 5 ff X Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death nours after death.

neral Director: After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

DEC 3 1 2009

			se Type or Pri			delible lnk. artment of H						ble.	43	140
		1 - For State Registrar			Ce	rtificate of	Death			Reg. No).			
2		Decedent's Name (First, Middle	e, Last)						2. Date of De	aath Da	v	Year	3. Time	of Death
Physicia		GLENN IRA SHAC	KELFORD						December			09	2156	6 M
/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location	of Death		40	. County	of Deeth		
LXdiiiii		Prince Georges	Hospital			Cheve	erly			P	rinc	e Ge	orge'	s
Funeral Director		5. Social Security Number 577-70-6468		je (In yrs. la: 7	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, Di July 30	nth ay, Year,	952	Cour	olace (State of try)	be or Foreign DC
		Usual Residence of Decedent											(0.1.114.	Oh Limbe
Marylan	tor	DC 10b. County			Town or Lo									City Limits
with the a or 28a	Funeral Director	10e. Street and Number 3725 Massachus	etts Ave S	SE		10f. Zip Code 2001	.9			10g. Ci	. Citizen of What Country? USA			
es 23	eral	11. Marital Status	12. Was Decedent		13	Was Decedent of H	lispanic Or	igin? (Spe	city Yes or N	0-	14. Race	e - Americ	can Indian	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Markical Examinat mentice required.	by Fun	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces' ned 1 ☐ Yes 2 ☑ If Yes Give	?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No			Rican, etc.)			k, White, B1a		
72 hour	leted t	15. Deceden	t's Education st grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during mos	st of worki	ng	16b. H	(ind of Bu	siness/In	dustry	
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uld be fill Aental Hy rkad oth tic even	To Be	17. Father's Name (First, Middle, Kenneth Warren					Wil:	ne1me	na She	phar				
od 2 shouth and N tth and N 27 is ma		19a. Informant's Name/Relationship (Type, Print) Jandel Fontaine - Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2210 Ritchie Road, Forrestville, Maryla												47
f Healitem		20a. Method of Disposition		COL	ace of Disponent	osition (Name of	ce)		Date			-	own, State	
ent o nt: If ry or		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) *4 □ Donation 5 □ Other (Specify) **Riverdale Park Crematory 12/30/2009 Riverdale Ri												
permit. P Departm Importer any injui		21. Signature of Funeral Service		10	7	2. Name and Addre	ss of Facili	y Joh	nson & NW, W	Jen ashi	kins ngto	Fun n, D	eral C 2(Home 0011
<i>₹</i>		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Finaf								arrest,	-		Approxir Interval Onset a	nate Between nd Death
Pnysician /Medical Examiner		disease or condition resulting in death)	a. Hypert Due to (or as			liovascul	ar Di	seas	e					
*	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a conseque	ence of):									
e executed ian and urial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or as	a conseque	equence of):									
ohysic the bi	dica		d											
To the Hospitel or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetel	death 3	□Ectopic pregnanc	у					te of deliv	ery Day	Year
that the ded by detail	/ Ph	Part If. Other significant conditi	ons contributing to death	but not resul	Iting in the o	underlying cause giv	ven in Part	I.	23e. Did	tobacco	use cont	ribute to	the cause	of death?
uires sign ld be	d b	Diabetes Melli	tus II						1 🗆	Yes 2	2 🗆 No	3 ☐ Pro	bably 4	₩Unknown
law requals been as been as been as been as been as been as a should be a shou	npiete	Angina Pectori	s							s an opsy formed?		Were autoprior to co	opsy findir omptetion	ngs available of cause of
The page	Con	Sèizure Disord	er						1□ Yes			1 🗌 Yes	2 No	
ertific actor,	Be	25. Was case referred to medica examiner?				04		e of Deat	h (Check only	one)				
hysi this c	7	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpat	-		IN SU DOA			me 5 Res				(y)	
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To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical (29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To the bes Exeminer: On the basis and manner s	of examination	vledge, dea on and/or i	th occurred at the ti nvestigation, in my	me, date a opinion, de	nd place, ath occur	and due to the red at the time	e cause(, date ar	s) and ma nd place,	anner as and due	stated. to the cau	se(s)
ro the	Me	29b. Signature and title of certifie	er 1	<u> </u>		29c. Licen:	se number			29d. D	ate signe	d (Month	, Dey, Yea	nr)
->-0		-	Don	دور د		D275	577			1	2/	24/	09	
2		30. Name and address of person Ophnell Cumberl	who completed cause of batch, MD, 8	death (Item	zsa) (Type entra	Print) 1 Ave., L	andov	er,	Maryla:	nd	2078.	5		

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) DEC 3 1 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2350 rbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Date of Dis., (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 🖾 F Months Days Hours Min. **Director** 578-38-1026 82 an. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 😾 Yes 2 🗌 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 4902 1st Street NW 20011 <u>United States</u> items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. þ 1 ☐ Yes 2 🔀 No If Yes, Give and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Negro Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene B. Williams Mary Lou Mont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Charles R. Scott/Spouse Washington, DC 20011 4902 1st NW other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State ò January 2010 injury o Donation 5 Dother (Specify) Landover, Maryland Harmony ure of Funeral Service Licent 21. Skinate 22. Name and Address of Facility Stewart Funeral Home, Inc. any 4001 Benning Rd. NEWashington, DC 23a. Part is Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exam Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached fi 9 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown s been significant spends by should by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate I Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) Hospital 2 🗷 No 1 Tes မ 1 M Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🔀 Natural injury 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certific 29d. Date signed (Month, Day, Year)

Registrar

State

of death (Item 23a) (Type, Print)

			For State Registrar	and M	ental Hyg	iene eg. No.20	109	43142					
			Decedent's Name (First, Middle, Last)				2. Date of Deat	eath 3. Time of Death		3. Time of Death			
	Physicia Medic	Ruth G. Snyder		, and the second			^M 12/21	Month 12/21/2009 Year		8:50am ^M			
	Examin		4a. Facility Name (if not institution, give si						4c. County of Death				
			Tate Hospice Hous	Linthicum If Under 1 Year If Under 24 Hrs. 8, Date			O Data of Bloth	Anne Arundel Birth 9. Birthplace (State or Foreign					
	Funeral Director		5. Social Security Number 6. Sex 1 6. Sex 1 5 6. Sex 1	7. Age (In yrs. 92		Months Days		Min.	8. Date of Birth	(91°7	9. Birth		
			Usual Residence of Decedent					1					
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ţō	10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Limits	
		irec	MD Anne A	rundel		Annapoli	s					1 Yes 2 No	
		a l	10e. Street and Number 10f. Zip Code 607 Americana Dr. A-35 21403							10g. Citizen of What Country? USA			
		Funeral Director		12. Was Decedent Ever in U	.S. 13.	Was Decedent of I	Hispanic Orig	gin? (Spec	cify Yes or No-	14. Ra		can Indian,	
9		by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2XX No		f Yes, specify Cub	an, Mexican	n, Puerto F	Rican, etc.)		ack, White,	etc. nite	
93		ted	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2x12x1N				Specif	y: W1	irre	
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Maryland	shoul and is m		19a. Informant's Name/Relationship (Type			ng Address (Stree							
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Ē	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service License										
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			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	ications that caused the dea								Approximate Interval Between	
	Physician/		Immediate Cause (Final disease or condition					ongestive Heart Fa			Onset and Death		
4	Medical Examiner		resulting in death) Due to (or as a consequence of):										
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Ö	w requires is been sig 2 should b	Bet	·						24a. Was a		. Were auto	opsy findings available completion of cause of	
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[a]	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be	25. Was case referred to medical examiner?		. Place of Death (Check only one)								
Ϋ́		2	1 Yes 2 No 27. Manper of Death	lospital: 1 Inpatient 2	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hon					ome 5 Residence 6 Other (Specify) HOSPICE			
n o		ate	1 ☑ Natural 5 ☐ Pending	(Month, Day, Year) injury work?					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Division of Vital Records,		Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office									
Ο̈́		ပြီ	I .	building, etc. (Specify)									
	lospit t hour unera	Medical	29a. Certifier (Check (
	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the first of the										se(s) and manner as stated. Date signed (Month, Day, Year)		
_	6 ≥ 6 8	296. Signature and title of certifier E W 34 F								December 21, 2009			
			30. Name and address of person who co	ompleted cause of death (life	em 23a) (Type.		(<u>ت</u>		OF COWL	per al	(2004	
BU Me Defense Hwy Suite 400, Annapolis, maryland 21401													
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Sign		1.11	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 45 P.M rimberly 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Dave Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Yrs. 27 Director March 9, 1982 214-17-1366 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X No Baltimore Maryland Anne Arundel 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 4019 Belle Grove Road, Apt. 7 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 😿 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Private - Child Elementary/Secondary (0-12) College (1-4 or 5+) Nanny Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James David Smith Barbara Susan Boracky 0 traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai 19901 Barbara S. Smith/Mother 129 Lady Bug Drive, Dover, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens 12/23/09 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, Jas nece 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LEUKEMIA CUTE MYELOID Sequentially list conditions, trans, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? A Q 2 No 1 Tes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes Yes 2 🗌 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 🗌 Yes 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

or Attending Physician: The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Hospital

Baltimore, Maryland 21215-0036

(check only 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

RES-000 Devember 19, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NILANJAN GLHOSH

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) TFC 23 2009

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. N2 0 0 9 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 15. 2009 DECEMBER 0825 AM HARRIET PORTER SWEETAK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 X F Yrs MATNE 03/02/1931 007-26-1246 78 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination, ust be notified at 1 X Yes 2 No Director MD TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21601 731 ELWOOD AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CORPORATE ADMINISTRATIVE ASSISTANT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental of Health and Ments item 27 is marked UNKNOWN EDWARD PORTER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 731 ELWOOD AVENUE, EASTON, MD ANDREW SWEETAK/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 12/18/2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Do not enter the mode of clying, scenar cardiac or sampled partiest, EASTON, Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each Jine. Immediate Cause (Final Second **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physiciar Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Yea Month in the past 12 menths? ō 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not result the underlying cause given in Part I. Part II. Other/significant conditions of Vital Records, Completed by zuch 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 2 🗆 No 1 ☐ Yes Physician: After this certification 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

10

501 DUTCHMAN'S LANE, EASTON, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Signature

WILLIAM H. WOOD, JR.

31. Date filed (Month, Day, Year)

Physician: The law requires that the death certificate be executed -trai P.O. Box 68760, physician the burial ЗS Division of Vital Records, page 2 s

Physician

/Medical

Examiner

Funeral

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Important: If item 27 is any Injury or off

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29a. Certifier

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JORGE H. ABREGO, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

29c. License number

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

598 CYNWOOD DRIVE, STE. 104, EASTON, MD 21601

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2948AM LYNELLE HARDER SHAW ecembo 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital at Talbot Easton Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 10/30/1947 NEW YORK 1 □ M 2 🔀 F Months Days Hours Min Director 214-52-7785 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Examiner must be notified 28a-f 1 X Yes 2 □ No MARYLAND **OUEEN ANNE OUEEN ANNE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13603 MAIN ST. 21657 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ъ þ 1 Never Married 2 Married Yes 2 No 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Divorced 4 Divorced WHITE the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **HOMEMAKER** OWN HOME 4 traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental! ပ is marked BARBARA ANN VIETH WILLIAM HARDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER SHAW / HUSBAND PO BOX 283, QUEEN ANNE, MD 21657 other Department of Healt Important: If item 2 any injury or other once. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State CAMBRIDGE, MD 12/23/2009 MID SHORE CREMATION CENTER 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funera 22. Name and Address of Facility MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to a a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of) the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate has page 2 performed? Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 No 1 🗌 Yes ျ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? __1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 14 Natural 5 Pending s after death. Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 18, 2009 1203pm /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Easton Memorial Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Days 0.28.10 Months 1**⊠**M 2□ F Very ano Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director as 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U 5 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced Lehit 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Xl ပ 19a. Informant's Name/Relationship (Type. Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanc ~2 26b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2:19.09 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee hore Cremation C zmevel Cembrid SPECK 21613 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart validire. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Cardiony TEQUS disease or condition resulting in death) Due to (or as a consi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause) Examiner -ears that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by uncontroller 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **Y** No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Funeral

Director

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than

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Physician

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After this certificate has funeral director, page 2 s ours after death.

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filled in by the fu To the Hospital within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

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31. Date filed (Month, Day, Year) DEC 21

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555 Cynward or Easton Mb 21601 100 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 12-18-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Margaret G. Summitt December 15, 2009 8:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Spa Creek Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-24-1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 78 Yrs. Director Texas 465-44-0999 Usual Residence of Deceden with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. If a Medical Erana natural be notified at Bowie. 1X Yes 2 No MD Director Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2509 Artesian Lane 20716 USA Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23s Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Housing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sallie P. Tomlinson White Gardner P. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2509 Artesian Lane, Bowie, MD 20716 Andrell B. Summitt, Jr./Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or once. Arlington Nat'l Cem. 01/04/2010 | Arlington, Virginia '4 Donation 5 Other (Specify) 21. Sign June uneral S vice Licens 22. Name and Address of Facility Beall Funeral Home ill 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final on Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medical use as t IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown á Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes & No this funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 03206 30. Name and address of erson o completed cause of death (Item 23a) (Type, Print) Drive Checker 2/08 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 55 P.M orraine ember 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗓 F May 2, Director 003-26-7968 New Hampshire Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 👿 No Examiner must be notified Funeral Directo Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number ō items 23a 108 Park Avenue 21037 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No ò Specify: If Yes, Give Year or Dates: þ Specify White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than matic event, the Me Lobbyist 12th Government 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donat Cantin Julienne Dionne 7 is marked traumatic e ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If Item 27 is any injury or other trau once. Laura Carr/ Daughter 2923 Edgewater Drive, Edgewater, MD 21037 20a. Method of Disposition

1 □ Burial 2 🖸 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12/21/09 <u>Edgewater</u>, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami physician and as the burial-tran Due to (or as a cor Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? Day 4 Pregnant at time of death
9 Unknown 5 Other (specify) signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed page 2 2 Be မ this funeral 2 Certification: After s after death. filled in by the

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: 24 hours a Funeral L

Baltimore, Maryland 21215-0036

				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 Inpatient 2 - Ef	R/Outpatient 3 🗆 DC	OA Other: 4 - Nursing Ho	me 5 Residence 6	☐ Other (Specify)
27. Manna of Death 11 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of lnjury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	occurred
3 Suicide 6 Could not be determined	e 28e. Place of injury - At home building, etc. (Specify)	ie, farm, street, factory	, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled niner: On the basis of examination	edge, death occurred on and/or investigation	at the time, date and place, i, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number RES-000

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pete Son

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

DEC 22 31. Date filed (Month,

29b. Signature and title of certifier

Registrar's Signature backs

Registrar

completely within 2

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20b. Place of Disposition (Name of CHESAPEAKE CREMATION) 20c. Location - City or Town, State CREMATION 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 20b. Place of Disposition (Name of CHESAPEAKE CREMATION) 21. Signals of Ediner Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited accounts (Final disease or condition resulting in death) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited accounts (Final disease or condition resulting in death) 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited accounts (Final disease or condition resulting in death) 25a. Part 1. Enter the disease, or complications that cause on each line. 25a. Part 2. Enter Underlying conditions, if any, loading to in mediate cause (Final disease or conditions, if any, loading to in mediate cause (Final disease or injury that initiated events resulting in death) Last 25b. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of):	, 00						
MAX CHRISTOPHER SHERMAN, JR 4a. Facility Name (if not institution, pice street and number) 4b. City, Town, or Location of Death 4c. County of Deat							
HOSPICE OF QUEEN ANNE'S HOSPICE CENTER Funeral Director	РМ						
Director Direct							
10a. State 10b. County 10c. City, Town or Location 10d. Inside City 10d. Inside	Foreign						
MAX CHRISTOPHER SHERMAN, SR. 19a. Informant's Name/Relationship (Type, Print)	Limits						
MAX CHRISTOPHER SHERMAN, SR. 19a. Informant's Name/Relationship (Type, Print)	2 🗆 No						
MAX CHRISTOPHER SHERMAN, SR. 19a. Informant's Name/Relationship (Type, Print)							
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20a. Method of Disposition Construction Constr							
20a. Method of Disposition Construction Constr							
Cemetery crematory or other place							
23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Betwoonset and Disease or condition resulting in death) Approximate Interval Betwoonset and Disease or condition resulting in death) Due to (or as a consequence of):							
Sequentially list conditions, Sequentially list conditions, Large List only one cause on each line. Interval Betwoen the Conset and Downser and Downser of the Conset and D	.A.						
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IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy 23d Date of delivery							
FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	ar						
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Set 10 Street is grant to other significant contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part 1.							
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autopsy performed? 1 Yes 2 No	15e O1						
25. Was case referred to medical examiner? 1	走						
The state of the s							
28d. Describe how injury occurred 28d. Describe how injury occurred							
28f. Location (Street and Number or Rural Route Number of Street) 28f. Location (Street and Number or Rural Route Number of Street) 28f. Location (Street and Number or Rural Route Number of Street)							
The state of the s	er stated.						
With Solution and address of person who completed cause of death (Item 23a) (Type, Print)	39						
30. Nahre and address of person who completed cause of death (Item 23a) (Type, Print) The mile Hanns is 115 Sault of DRIVE STORY LEE ms 21666							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Harms' on 115 Sacret Drive Stocks as 21666 State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Agree Agree Agree 33. Registrar's Agree 34. Registrar's Agree 35. Registrar's Agree 36. Agree 37. Registrar's Agree 38. Registrar's Agree 39. Registrar's Agree 49. R							

State of Maryland / Department of Health and Mental Hygiene 43151 Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Shirley Sapin 2009 December 22, 12:45 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Hillhaven Nursing Center, Inc. Adelphi If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month Day, Dec. 11, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Hours 111-18-1706 83 New York Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Maryland Mon toomerv Silver Spring 듑 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9039 Sligo Creek Parkway, #1206 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Maryland 21215-0036 Yes 2 X No Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Clinic Psychologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sam Sadow Bertha Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Joan Sapin/Daughter 9039 Sligo Creek Parkway, Apt. 1206, Silver Spring, MD 20901 Baltimore, Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot ☐ Burial 2 【 Cremation 3 ☐ Removal from State 9 Metropolitan Crematory 2009 Alexandria, Virginia 4 Donation 5 Other (Specify) 22 Name and Address of Eacility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licens 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest K, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Yrs• Immediate Cause (Final Physician/ Interstitial Lung Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 phys the l attending p IF FFMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🖾 No Year Month Day Pregnant at time of death signed by the a d be detached f g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Records, icate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No 1 🗌 Yes Yes 2x No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) of Vital Be Hospital: 2 🕇 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dli 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural 5 Pending Division Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dec. 23, 2009 D41978 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nader Tavakuli, MD 12200 Annapolis Road, Glenn Dale, MD 20769 31. Date filed (Mont DEC 28 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sharpe Mary Margaret 9:10 p^M December 24. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) May 26, 1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 278-03-5521 92 Ĩ/917 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ms 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director Montgomery Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Wayne Place 20910 USA Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event inconse. Armed Forces? 1 ∐Yes 2 1 No Black, White, etc Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augustus Cheek ၉ Florence McDermott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Dolores Baumann/Daughter 14409 Fairdale Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Spring, MD 20901 CHAN Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on a ach line. _Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 cate has been si , page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X X 100 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahryar Davari, MD 10110 Molecular Drive, #206, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State ack **DEC 28** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jemima Kezia Stewart 2009 1:05 A Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Hours Min. 08/15/1916 _{Country)} Jamaica Director 93 218-94-5078 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20877 Jamaica 7601 Creekstone Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: Black Completed 3 X Widowed 4 ☐ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isadora Lewis Ezekiel Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ludel B. Black (Daughter) 7601 Creekstone Court Gaithersburg, MD. 20877 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of January 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 2010 Germantown, Maryland 21. Signature of Euneral Service Licer 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 art 1. Enter the disean, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Ruptured Onset and Death Imme fir te Cause Final Physician/ Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): and I-transit Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, HTN, DM Completed 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 1 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Matural injury 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Ar completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number

Registrar
DHMH 17 Rev 7/2009

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ichael

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MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18701

10050410

Prince Philip Dr., Olney 20832

12/24/09

Baltimore, Maryland 21215-0036

40	
Sta Registr	

		For State Registrar	1 1000	State of	of Marylan	nd / Depa		t of H	ealth a		lental Hy			43154
		1. Decedent's Name	e (First, Middle								2. Date of De Month		Year	3. Time of Death
Physicia /Medic		Gary		Rexfor	.d		Shro	ut			Decemb	er 27,	2009	2:00 P M
Examin	er	4a. Facility Name (I							Location			4c. Cou	nty of Death	
		Country 5. Social Security N		Residenc	7. Age (In yrs.	(act hirthday)			rland		8. Date of Bir	th	Alleg	
Funeral Director		220-32-3 Usual Residence of	8838	11√∏ M 2 □ F	7. Age (myrs.	Yrs.	Months	Days	Hours	Min.	(Month, Da 10/24/	ay, Year)		place (State or Foreign intry) cyland
yland now		10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
e Mar ka-fsh tiffed	ctor	MD	A.	llegany		Cu	mberl	and						1 □ Yes 2 汉 No
vith the	Dire	10e. Street and Nur		tie Road,	NF		10f. Zip		502			10g. Citizen	of What Cou USA	intry?
leath v	Funeral Director	11. Marital Status	CIII IS	12. Was Dec	edent Ever in U	.S. 13.	Was Dece			igin? (Sp	ecify Yes or No Rican, etc.))- 14. [Race - Ameri	
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Evaninal matter and the notified at	by Fur	1 Never Marri		ed 1 □Yes If Yes, G	2 XNo iive		If Yes, spec 1 □ Yes		n, Mexicai Specify:		Rican, etc.)	1	Black, White, ec <i>ify:</i> W	etc. Ihite
hours hural"	ed b	3 Widowed	4 L Divorced 15. Decedent	Year or I	Dates:	16a. Dece	dent's Usua	al Occupa	ation			16b. Kind o	f Business/Ir	
hin 72 e. an "n a Medik	Completed	(Spec	ify only highes	t grade completed,) (1-4or 5+)	(Give life.	kind of wo DO NOT us	k done a se retired	furing mos ')		ing			
ed wit	Con	12				Buil	ding	Insp			(First Adiddle			rnment
d be fill ental Heed out	o Be	17. Father's Name (Austin		Shrout	,			ers Name ttie	e <i>(First, Middle</i> Pen	, waiden sun .elope	4000	wigg
shoul and Ma s marl umati	To	19a. Informant's Na				_		(Street a	and Numb	er or Run	al Route Numb		wn, State, Zi	ip Code)
and 2 lealth a m 27 is				out / Wif							E, Cumb			21502
ages 1 nt of H : If ite		20a. Method of Disp 1 ☐ Burial 2	Cremation	3 🗆 Removal from		Place of Dispo cemetery, crea mberla:					Date		on-City or T erland	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 21. Signature of Fu			Cui	2:	2. Name ar	d Addres	ss of Facili	ty Ada	ams Fam	ily Fu	neral	Home, P.A.
ă∆ ⊆ ≅ ⊙		23a. Part 1. Enter the shock, or hea	he disease, or	complications that	caused the deat						, Cumbe		MD 2	Approximate Interval Between
Physician /Medical		Immediate Cause (disease or condition resulting in death)	(Final	_a	wels to	ce	De	n en	DA					Onset and Death
Examiner				Due to	(or as a consist Emplication	fuence of):	/ah	e	Se	174	uer			
ited nsit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, imediate irlying injury	Due to	(or as conseq	juence of):	Par	20	certe	en+				
te be executed ysician and e burial-transit		that initiated events resulting in death) l	Last	c. Due to	(or as a conseq	quence of):	wa (cr		11				
icate b	dical			d										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live	utcome of pregnation 2 Feta gnant at time of a gnown	al death 3[⊒ Ectopic p ⊒ Other (s		У			23d.	Date of deli	very Day Year
s that gned by e deta	by Ph	Part II. Other signif	ficant condition	ns contributing to	death but not res	sulting in the u	inderlying c	ause give	en in Part	l.	23e. Did	tobacco use o	contribute to	the cause of death?
equire sen siç ould b	ted k					_					1 🗆	Yes 2 ☑ N	o 3□ Pro	obably 4 Unknown
The law rate has be	Completed					· · · · · · · · · · · · · · · · ·					24a. Was auto perfo 1 □ Yes		prior to c death?	topsy findings available completion of cause of
cian: ertific ictor,	Be (25. Was case refer examiner?	red to medical					-			th (Check only		Λασ	rigt od
Physical this call dire		1 Yes 2			Inpatient 2			_		ursing Ho				sisted Living
ath. rr: After ne funer	ation	27. Manner of Deat 1 Natural 2 Accident	5 ☐ Pending investig	g (Mo lation	e of Injury nth, Day, Year)	28b. Time of Injury	M 2	8c. Injur Work 1 □	yat ⟨? Yes 2□	No	28d. Describe	now injury oc	currea	
al or Attus s after de al Directo ed in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could r	Laca 200. Flat	e of Injury - At h ding, etc. (Speci	ome, farm, st	reet, factory	, office			28f. Location City or To	(Street and N wn, State)	umber or Ru	ral Route Number,
e Hospit 124 hour e Funera iletely filli	edical (29a. Certifler (Check only one)		g Physician: To th Examiner: On the and ma										
.)	Me	29b. Signature and	title of certified	11/2	1-0	1 111	290	_	e number				gned (Month ber 28	n, Day, Year) 8, 2009
40		30. Name and addin						Wals	sh Ro:	ad.	Cumberl	and. M	ID 215	502
Sta	te	31. Date filed (Mon	th, Day, Year)	32.	Begistrar's Signa	ature				7				
Registr	_		DEC 28	2009	Lotter de 1	h h	ares	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	aryıan		rtment <i>tificate</i>			-	_	0000	10155
			Registrar 1. Decedent's Name (First	st, Middle, Lasi	t)		061	incate_	OI Dec		2. Date of De		C U U J	3. Time of Death
	Physici /Medio		Marth	ha	Margar	et	Swar	nson-L	uman		Month Decem	ber Day	25, Year 200	9 9:35 P M
and a second	Examin		4a. Facility Name (If not in		street and number)					ation of Death		4c.	County of Dea	
4			4 Richard No. Social Security Number	5	7 40	o (In ure	ast birthday)	If Under 1	LaVal	e Inder 24 Hrs.	8. Date of Bir	th	Alle	0
	Funeral Director		178-20-893	1		93	Yrs.			ours Min.	8. Date of Bir (Month, Da 04/19/	iy, Year) 1916	Pen	thplace (State or Foreign buntry) nsylvania
	ס		Usual Residence of Dece	edent		40.00	Ŧ							10d. Inside City Limits
	larylar shov	or	10a. State 10b.	County Alleg	ranv	TOC. CIT	y, Town or Lo	LaVa	le					1 ☐ Yes 2 ☑ No
	the N 28a-f notifie	Director	10e. Street and Number					10f. Zip C				10g. Cit	izen of What Co	ountry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Modical Examiner must be notified at once.	al Di	4 Richa	rd Way					2	1502			US	A
	r deat	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. V	Vas Deceder Yes, specif	nt of Hispan y Cuban, Me	nic Origin? (Sp exican, Puerto	pecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit	
36	rs afte		1 ☐ Never Married 2 3 【☐ Widowed 4 ☐ □		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No.	1	□Yes 2	X No Sp	ecify:			Specify:	White
9-0	2 hou atura	ted	**	Decedent's Edu Ny highest grad			16a. Deced	lent's Usual	Occupation		lalas as	16b. K	ind of Business.	
21	ithin 7 ne. nan "n	Completed by	Elementary/Secondary		College (1-4or 5	i+)	ľ			g most of work	King			
121	led w Hygiel her tl		12 17. Father's Name (First,	Middle Last)			S	ecreta		Mother's Nam	ne (First, Middle		penter:	union
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	To Be	Thomas		efferson	J	ohns			llie	_	atri		Crawford
ary	shoul and M s marl umati	۴	19a. Informant's Name/P	Relationship (7	ype. Print)		19b. Mailin	g Address (Street and N	Number or Ru	ral Route Numb	er, City o	or Town, State,	Zip Code)
	and 2 ealth a n 27 is		Thomas R.	Swanso	n / Son						Road, Be			15522
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1 X Burial 2 □ Cre		Removal from State	1	lace of Disport emetery, cren			- 1	Date		ocation - City or	
Iţi	urtmer artmer ortant: njury		4 Donation 5 □ 0			Bro	okvill		•	,	30/2009 dams Fan		rookvil. Funera	le, PA L Home, P.A.
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Klyll	J. W.	dam						Cumbe	-		21502
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each life. Immediate Cause (Final							rrest,		Approximate Interval Between Onset and Death					
	Physician /Medical		disease or condition resulting in death)	-	a. Ou- to (or as	1750	uence of):	ligo.	cmy	1009	hy			1-2125
7	Examiner				Cor	MAR	Zu /	Setel	24	Dist	15e			
	ed sit	iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate	Due to (or as	a conseq	unce of):		/					
	execut and al-tran	Examiner	that initiated events resulting in death) Last		cDue to (or as	a conseq	uence of):							
68760,	ificate be executed g physician and as the burial-transit	edical E			d									
		Medi	IF FEMALE:							-	÷		10/55	
Вох	attend for use	ian/	23b. Was decedent preg in the past 12 month	Derit	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3	Ectopic pre				1	23d. Date of de Month	livery Day Year
Ö	the de	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9 Unknown	t time or c	Jean 3L							
s, P.	The law requires that the death cert ate has been signed by the attendingage 2 should be detached for use	by PI	Part II. Other significant	conditions co	ontributing to death b	ut not resi	ulting in the ur	nderlying cau	use given in	Part I.				o the cause of death?
ord	een si nould b	ted									1 🗆	Yes 2		robably 4 Unknown
360	e law has b je 2 st	Completed									24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
la			25. Was case referred	medical						Diago of Dea		2 N O		s 2 No
	Physician; r this certific ral director,	o Be	examiner?		Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatier	it 3 □ DOA					6 ☐ Other (Spe	ecify)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Note Residence 6 Other: 4 Nursing Home 5 Note Resid														
Use the second s								hand Banda Manhan						
The state of the s							urai noute Number,							
The state of the s								as stated. e to the cause(s)						
	29c. License number 29d. Date signed (Month, Day, Year)								th, Day, Year)					
	43		•	1///	Valo	1	M	I	22181			Dec	ember 2	8, 2009
			30. Name and address o		//				ch Po	ad Ci	mberlan	d M	ID 2150	12
	Sta	ite.	Gary L 31. Date filed (Month, Da		32, Regist			op wal	. 110.	au, ou	UGI Lall	u, 1'.		
			I DEC	28 20	00 2		1 1							

Division of Vital Records. P.O. Box 68760.

Hospital or Attending Physician: The law requires that the death certificate be executed Certification: To within 24 hours after deatl To the Funeral Director: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Mpnth, Day, Year) 29b. Signature and title of certifier Dacem. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kent Ave soite 204 Combidand nes Muhhammid Nacem MD 625 38 Registrar's Signature 31. Date filed (Mod A Ray, (Yes) 2010 State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Senkbeil Berta Schneebeli 0605 , 2009 100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisburg oder 1 Year | If Under 24 Hrs. Wicomica Salisbury Rehabilitation + Nursing(8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 😿 F 214-10-7153 **Director** Switzerland 03/06/1918 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examirar must be notified at 1 X Yes 2 No Director Maryland Wicomico Salisbury hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA Haryland 21215-0036 200 Civic Ave. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other tha any injury or other traumatic event, Ite-once. domestic housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Schneebeli Berta Vollenweider ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Edward G. Senkbeil/son 31229 Ward Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 12/30/09 Salisbuly Find 22 Name and Address of Facility Holloway Funeral Home Professional Association re of Funeral 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causely each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence o law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician as the burial. Box 68760. Physician/Medical attending pl IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) P.0. 9 Unknown s been signed by the should be detachε 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 2 No 1 ☐ Yes 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🚾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

William H. Robins, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State C State Registrar	i wai yiai k		tificate of L		-	Reg. No. 20	109	43158
f	Physicia	an	1. Decedent's Name (First, Middle, Last)	SEPH	-04	HED.	To	2. Date of De		Year	3. Time of Death
*	/Medic Examin		4a. Facility Name (If not institution, give street and nu	mber)		4b. City, Town, or	Location of Death	1	4c. County		
1			Howard County General			Columb				ward	
	Funeral Director		5. Social Security Number 6. Sex 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 2 1	7. Age (In yrs. la	ast birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 9/28/19	th ly, <i>Year)</i> 932	9. Birthpla Count Mary	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10	d. Inside City Limits
	Mary a-f sh	tor	Md. Howard	F	Ellicot	tt City					1 □Yes 2XINo
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	ath wi		9926 Windflower Drive			21042			USZ		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Marieal Event instrumet be notified at once.	by Funeral	Armed F	ve 1971	'	Vas Decedent of Hi fYes, specify Cuba I □Yes 2ŽNo	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Ye's or No Rican, etc.)		ice - America ack, Whit <i>e</i> , el ify: Whit	tc.
2-0	72 hou	Completed by	15. Decedent's Education (Specify only highest grade completed)			lent's Usual Occupa		ina	16b. Kind of B	Jusiness/Inde	ustry
2	ithin 7 ne. han "r	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired) -	ng .	В	GE	
2	iled w Hygie ther th	Co	17. Father's Name (First, Middle, Last)		Sı	pervisor	18. Mother's Name	e (First, Middle			
and	d be f ental ked of	To Be	Raymond J. Suter Sr.					rude M.		,	
ary	shoul and M s marl umati	Ĕ	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a				n, State, Zip	Code)
Ž	and 2 salth a n 27 is er tra		Rosalea Suter/wife			Windflow		Ellico		·	
ore	es 1 and He He He He He He He He He He He He He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from			sition (Name of natory or other plac		Date	20c. Location	- City or Tov	vn, State
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Baltimore, Maryland	permit Depar Impor any In	9,000 9,000 1100 15 1111 011 0011111 1110 1110									id. 21043
shork or heart failure it ist only one cause on each line									Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	(or as a consequ	ence of):	- 21cm	1 11 2 0	1-			
	Examme	-	Sequentially list conditions.	(or as a consequ		PHO I	ngor.	171 17	7		
	nsit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	O Mar	ience on).	ARDIO, RETE	24	DISE	45/		
Ć,	execun and ial-tra	Exa	that initiated events resulting in death) Last Due to	(or as a consequ		- / / ~					
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O. Box	death ceri le attendin le for use a	Physician/N	23b. Was decedent pregnant 1 Live	tcome of pregnar birth 2 Fetal mant at time of de	death 3	Ectopic pregnancy Other (specify)	<i>y</i>			ate of delive Ionth	ry Day Year
P.0	that the de ned by the a detached t	Phys	9 Unknown		data a ta aban su		- i- Death	220 Did	tabagas usa gar	ntribute to th	e cause of death?
Records,	w requires the sbeen signer should be de	ð	Part II. Other significant conditions contributing to o	eath but not resu	iiting in the ur	nderlying cause give	en in Part I.				ably 4 Dunknown
l Rec	2 2 2	Completed						24a. Was auto perfo 1 □Yes			osy findings available inpletion of cause of 2 PNo
Viital	ding Physician: The I.n. After this certificate ha funeral director, page	Be (25. Was case referred to nedical examiner?			l out	26. Place of Deat	h (Check only	one)		
of	Physi this c	<u>۲</u>	1 Yes 2 No Hospital: 1 28a. Date	Inpatient 2 I	ER/Outpatier 28b. Time of		4 LI Nursing Ho		idence 6 O)
u O	ding h. After funer	tion	1 I Pending (Mo	oth, Day, Year)	Injury	Worl	yai (? Yes 2 □ No	280. Describe	now injury occu	ned	
Division of	or Attendi after death. Director: A in by the fu	e a 2 □ Accident investigation									l Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) (Check only one)	e best of my know basis of examinat oner stated.	wledge, deatl tion and/or in	n occurred at the tirvestigation, in my c	me, date and place, pinion, death occur	and due to the	e cause(s) and r , date and place	nanner as st and due to	tated. the cause(s)
	To the within 2 To the complet	Mec	, and ma			29c. Licens	e number		29d. Date sign	ed (Month, I	Day, Year)
	->F0		29b. Signature and title of certifier	1		175	3987	7	Dec 2	120	109
i.	04/		30. Name and address of person who completed cau	se of death (Item	23a) (Type,	Print) KEN	onumber 3987 NETT	166	NO	212	210
Ī	Sta Registr		31. Date filed (Month, Day, Year) 32. DEC 2 1 2009	Registrar's Signat	ture .	barkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 Mas cember /Medical 4c. County of Death Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayviewi (enter Medical timol 150 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Hours Min 1**X** M 2□ F Days 81 2-7-1928 WV **Director** 213-24-8063 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2 X No Director MDBaltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2021 Paulette Road Funeral U.S 21222 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black ⋛ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister Clergy/Pastor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas H. Smith ပ Eliza Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau Paulette Road, Dundalk, MD 21222
ition (Name of Date 20c. Location - City or Town, State 2021 David Smith/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Owings Mill, 1 ☐ Xurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA 12-29-2009 4 ☐ Donation 5 ☐ Other (Specify) 21117 22. Name and Address of Facility 917 W. Isabella St Funeral 5 Bennie Smith Salisbury, MD 21801 Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Ye ar Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Vunknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 1 ☐ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

IVA

Patrick

31. Date filed (Month, Day, Year)

4940

32. R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemmin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		ŀ	1 - State of Maryl State of Maryl Registrar		artment of F tificate of E			Jiene Reg. No20(9	43160	
	Physicia		1. Decedent's Name (First, Middle, Last) Jessie L. Tribble				2. Date of Dea			3. Time of Death 4:11 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospita	1	4b. City, Town, or Takoma	Location of Death		4c. County of	of Death		
-	Funeral Director			rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 107087	1	9. Birthp	lace (State or Foreign Carolina	
	and show fat	or	Usual Residence of Decedent 10a. State 10b. County 10c	City, Town or Lo	cation				1	0d. Inside City Limits	
	e Maryl 28a-f notifie	Jirect		Hyattsvi						1 x Pryes 2 □ No	
	with th	Funeral Director	10e. Street and Number 5420 Sargent Road		10f. Zip Code 20782	2		10g. Citizen of W U nited S		· .	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.		Vas Decedent of Hir f Yes, specify Cubar I ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)	Black	- America , White, 6 Blac		
15-0	72 hou n "natu Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired)	ation Juring most of work	ing	16b. Kind of Bus	siness Inc	dustry	
212	l within ygiene. her tha t, the N		Elementary/Seconday (0-12) College (1-4 or 5+)		ria Worke	er		Hospita	1		
Baltimore, Maryland 21215-0036	be filed ental Hy ked otf ic even	To Be	17. Father's Name (First, Middle, Last) George Floyd Smith			18. Mother's Nam Lovenia		Maiden Surname)			
lary	should and Mar is mar raumat	1 8	19a. Informant's Name/Relationship (Type, Print) Mary F. Henry Daughter	1	ng Address (Street a					code)	
ē,	1 and 2 f Health item 27 other t		20a. Method of Disposition 20	b. Place of Dispo	Sargent I	!	tsville Date	, MD 20 20c. Location - 0	782 City or To	wn, State	
imo	Page iment o tant: If tant: If jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	natory or other place n Nationa					Virginia	
Bai	permit Depar Impor any in once,	b 0	21. genatur Funeral Struck Lice Lice use 22. Name and Address of Facility John T. Rhines Funer 3005 12th Street, NE Washington, DC								
	Physician,	8 5	28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
	Medical Examiner										
		iner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying	sequence ot):					1		
	ecuted and I-transit	Exam	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a cons	sequence of):					+		
200	cate be executed physician and s the burial-transit	edical Examiner	d						_		
Box 687	_ 6	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon		ery Day Year	
P.O.	that the	by Ph	Part II. Other significant conditions contributing to death but no	resulting in the u	inderlying cause glv	en in Part I.	23e. Did to	bacco use contri	oute to th	e cause of death?	
rds,	requires	eted	17/6/16/15/10/	1.000						pably 4 Unknown	
Division of Vital Records,	The law ate has t	Completed	COOLGESTIVE HEART FAIL	MLE			24a. Was a autop perfor	med? de	rior to coreath?	osy findings available impletion of cause of	
ta Ta	sician: T certifica irector, p	Be	25. Was case referred to medical examiner?		LOthe	ace of Death (Chec	k only one)				
o o	ig Phys ter this neral dir		P								
Sion	vttendir death. ctor: Af y the fu	28a. Date of injury 28b. Time of injury at work? 1 Natural 5 Pending 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurre									
DIX	Hospital or Attending Physician: The law 24 hours after death. Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s	1 1									
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral discompleted filled fil	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								use(s) and manner stated.	
	Nithir Withir Comp	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
	17)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								1 2007	
	10		VICTOR ONE IAM 7325 31. Date filed (Month, Day, Year) 32. Registrar's Si	-1 -1 1 1 1 1 2	var facti	MAY GR	E6-16-61	of ma	RYLA	mp 20A2	
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SIRRET, Herperstown, MD, 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Acu

JAN 6

Dr. Maalerb

31. Date filed (Month, Day,

368 MLU

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Twigg Betty Lee December 2009 5:30 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11954 Sherree Lane Princess Anne Somerset If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 316-50-4778 67 Director 04-05-1942 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Somerset Princess Anne 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 11954 Sherree Lane 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine. 1 ☐ Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Johnson Elizabeth Bradford ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terry Twigg/Husband 11954 Sherree Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Paurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12/21/2009 Quinton Cemetery Pocomoke City, Maryland ignature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home Part1. Enter the disease, or complications they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Let under the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1 Yes 2 4No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1☐ Yes 2X No Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this s after deaun.
al Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/2/12009 D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALL HIGHWAY CRISTIELD MD 21817 . VIJAY KARUMBUNATUAN

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

parker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day 11:28 P M 2009 Wallace Edward Thompson December 13, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 28474 Pinehurst Circle Talbot Easton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑** M 2□ F Months Days Hours Min. **Director** 64 218-40-6287 03/15/1945 Delaware Usual Residence of Decedent death with the Maryland 10a. State show 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, the Medical Examinat must be notified at Director 1X Yes 2 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28474 Pinehurst Circle Funeral 21601 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: <u>\$</u> White Specify. 3 ☐ Widowed 4 👿 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Realty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace E. Thompson Catherine Hardy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 2 Casey Thompson/son O. Box 4703 Ocean City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery 12/17/2009 Camden, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEPATOCELLULAR CARCINOMA yr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) n signed by the a Id be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has page 2 s autopsy performed Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division of Vital Records, or Attending Physician:

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu hours after death, To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature

8221 David

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teal Drive, Ste. 301

Easton

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Amended #s 26, 12/21/09, per	28b; nls, Please Type phy., Allegany Co. Sta	or Print in Black In	delible Ink. Ensure A	II Copies Are	Legible.				
	For State Registrar	te of Maryland / Depa <i>Ce</i>	artment of Health and N rtificate of Death	nemai mygiene Reg. No.					
	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death				
Physician /Medical	Donald Ray	ressle	er	Dec 18,					
Examiner	4a. Facility Name (If not institution, give street a	Creek Road	4b. City, Town, or Location of Death Frostburg		County of Death Allegany				
Funeral Director	5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jul 7, 194	9. Birthplace (State or Foreign Country)				
D	Usual Residence of Decedent								
× 6 m	10a. State 10b. County Mononga	llia 10c. City, Town or Lo	rgantown		10d. Inside City Limits 1 □Yes 2 □ No				
fier death with the Mar ritems 23a or 28a-f st instruct to notified Funeral Director	10e. Street and Number 242 Rolling Hills		10f. Zip Code 26508	10g. Cit	izen of What Country? USA				
death	11. Marital Status 12. Wa	is Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.				
036 urs after al", or ite	1 Never Married 2 Married 1 If Y	AVAC 2 No	1 □Yes 2 □No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: white				
21215-003(ed within 72 hours a ygiene. "natural", of the Marcial Exert, the Marcial Exert. Completed by	15. Decedent's Education (Specify only highest grade comp	oleted) I (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		ind of Business/Industry				
212 d withir giene.	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	bled	n/	′a				
and be filed be filed of the event,	17. Father's Name (First, Middle, Last) Jess Tressler		18. Mother's Nam Ruth	e (First, Middle, Maiden McCulloug					
aryla should I and Men marke umatic	19a. Informant's Name/Relationship (Type. Pri	nt) 19b. Maili	ng Address (Street and Number or Rui	ral Route Number, City o	or Town, State, Zip Code)				
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours aft partment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural", or y injury or other traumatic event, the Marical Every to ge.	Doris Tressler		12 Rolling Hills	Morgan	town WV 26508 ocation - City or Town, State				
MOCr Pages ' ent of H nt: If ite	20a. Method of Disposition 1 ☐ Burial 2 ☐ Aremation 3 ☐ Remova 4 ☐ Donation _5 ☐ Other (Specify) /	from State Hastings F	psition (Name of matory or other place) uneral Home, Inc.		Morgantown WV				
Balti Dermit. Departm mporta any inju nnce.	21. Signature of Funeral Source Victorse	2	2. Name and Address of Eacility Scarpelli Funeral H		MD 04500				
	MD 21502 Approximate Interval Between								
Physician	shock, or h , t fail r . List o y one a Immediate Ca se (Final disease or condition		GUNSHOT WO	UNDTOH	. Onset and Death				
/Medical Examiner	resulting in direction	Due to (or as a consequence of):							
iner	b. Due to (or as a consequence of): attentially list conditions, any, leading to immediate uses. Enter Underlying attentiated events c.								
o, executed in and ial-transit	that initiated events c								
3760 ate be c hysiciar the burit	d								
oertific certific se as the se as th	IF FEMALE: 23c. If y	ves, outcome of pregnancy	-		23d. Date of delivery				
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed rithis certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the buriat-transit: To Be Completed by Physician/Medical Examir	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year				
lS, P. es that t igned by be detac	Part II. Other significant conditions contributi	ng to death but not resulting in the L	inderlying cause given in Part I.		use contribute to the cause of death?				
cord requir requir should I				1 Yes 2	24b. Were autopsy findings available				
Division of Vital Records, in a Attending Physician: The law requires the er dea h. Director After this certificate has been signed in by the funeral director, page 2 should be dertification: To Be Completed by				autopsy performed?	prior to completion of cause of death?				
/ital	25. Was case referred to medical examiner?			th (Check only one)					
of \Physical Physical directions	Yes 2 No Hospita 27. Manner of Death 28a	a. Date of Injury 28b. Time of		ome _5 Residence 28d. Describe how inju					
Vision Attending or dea h. ector After by the fune	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury 2-18-2009 9:08 1	Work? 1 □ Yes 2 ☑ No	SUBJECT SI					
Division of tal or Attending Physics are deal. Tal Circetor After this ried in by the funeral dir	4 ☐ Homicide	e. Place of Injury - At home, farm, st building, etc. (Specify) DAYS I NH HOTE		28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e) 11100 NEW 650R6E 3				
草 5 上 章 〇	29a. Certifier (Check only 1 Certifying Physician Medical Examiner: C	: To the best of my knowledge, dea	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause(ROSTBURG, MD 71537 s) and manner as stated. nd place, and due to the cause(s)				
o the Hosp within 24 hou o the Fune completely fil	29b. Signature and title of certifier	nd manner stated.	29c. License number	29d. Da	ate signed (Month, Day, Year)				
6 3 5	> Scent /	ver	D09157	1:	2-20-2009				
NR	30. Name and address of person who complete PAUL SNOW, W	ed cause of death (Item 23a) (Type 1.D. 124 W.	D09157 300 ST. Cun	BERLAND.	MD 21502				
State Registrar	31. Date filed (Month, Day, Year) DEC 21 2009	32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death a4 -Joan Tecott Physician/ 2:50 AM 13 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at Wiconico Salisbur the Lake If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2**X** F Months Days Hours Min 06/06/1935 New Jersey 141-28-6412 Director 74 Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21811 77 Pinehurst Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give white 3 X Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "natur aumatic event, the Medical ! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sales representative insurance Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Yetta Tractenberg David Lesnik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)
72 Burnett Terrace, West Oranage, NJ 07052 19a. Informant's Name/Relationship (Type, Print) Karen Tecott/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Salisbury Crematory 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 12/28/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22Holloway Pureral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 501 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one adiens that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TRRINIS CARCINDMA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown signed by the atte Month 5 Other (specify) Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/ No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy this certificate 1 Yes 2 TNO 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053410 24-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIS 733 21802 Huston SAWSW 31. Date filed (Month, Day, Year) UEC 29 2009 32. Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43166 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 18, 2009 Physician/ 10:30a м Dorothy L. Tripp Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Stevensville 603 Broadcreek Drive If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Month, Day, July 29 Washington, 1 □ M 2 🛣 F Director 212-58-8460 57 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No MD Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21666 USA 603 Broadcreek Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11, Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trade Association <u>Administrative Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald Alfred Gardiner, Jr. Joan Marie Armacost permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Alan Tripp/husband 603 Broadcreek Drive Stevensville, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 12/21/09 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Golffig Home Factremation Service P.O.Box 784 P.A. Clarksville,MD Heckrotte. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ a Ovarian Cancer disease or condition VORES Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Directo (presia donsequence or; If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last tending physician for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐XNo been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, autopsy performed? Yes 2 No page 2 this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Hospital: Other 2X No 1 🗌 Yes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending injury 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, after determined building, etc. (Specify) within 24 hours a To the Funeral D Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29142 December 18, 2009 al Re 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Boice, M.D. 10301 Georgia Ave.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

32. Registrar's Signature

a salate s

Suite 205 Silver Spring, MD 20902

		-	For State Registrar	State of M	aryland / l		rtment of H rtificate of L		lental Hy	giene Reg. Na	2009	43167
	21		1. Decedent's Name (First, Middle,	,					Date of De Month	ath Day		3. Time of Death
i.	Physicia Medic/	al	Elizabeth D.						Decemb	er 2	0, 2009	6:30 A ^M
)	Examin	er	4a. Facility Name (If not institution, g Atria Manresa	give street and number) L			4b. City, Town, or An	napolis		40.	County of Deat Anne	Arundel
F	uneral		5. Social Security Number 6	. Sex 7. Ag	ge (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birt	hplace (State or Foreign untry)
D	irector		186-14-3376 Usual Residence of Decedent	1	87	Yrs.			4/22	/192	2 Pe	nnsylvania
ryland	how		10a. State 10b. County		10c. City, Tow							10d. Inside City Limits
he Ma	28a-f s	ecto	2	Arundel	Anr	napo	lis			10a Cit	tizen of What Co	1 □ Yes 2 No
with t	3a or 3	Funeral Director	10e. Street and Number 85 Manresa Roa	ad			214	109		rog. Oil	USA	
r death	ens 2	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, White	
should be filed within 72 hours after death with the Maryland	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Examination until be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	d 1 □Yes 2 🔀 If Yes, Give Year or Dates:	No		□Yes 2 ½ No	Specify:			Specify: Wh	ite
72 hou	natura Jical E	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	(Give	dent's Usual Occupa	luring most of work	ing	16b. K	ind of Business/	Industry
within	than the Me	duc	Elementary/Secondary (0-12)	College (1-4or		ach:	00 NOT use retired er)			Educati	on
e filed	other vent, I	Be C	17. Father's Name (First, Middle, La		1 2	<u> </u>		18. Mother's Name	e (First, Middle			
ould b	arked atic e	입	John Deviln						erine M			7.0.0
d 2 sh	27 is m traum		19a. Informant's Name/Relationship Helen Theresa I				g Address (Street a					
is tan	item		20a. Method of Disposition		20b. Place o		sition (Name of natory or other place		Date		ocation - City or	
. Page	ant: If jury or		1 ☐ Burial 2 🙀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Lin	coln Crem	atory 12	/24/09	Br	entwood	, MD
permit Depar	Impor any In		21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD									
			23a. Part 1. Enter the disease, or co	omplications that cause	d the death. Do						широтт	Approximate Interval Between
shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal Failure disease or condition										Onset and Death 3 years		
	edical iminer		resulting in death)		a consequence							20 years
		Jer	Sequentially list conditions, if any, leading to immediate	U	a consequence							20 years
ecuted	and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	onary Hy		tension					5 years
icate be executed	physician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	or):						
tificate	ig phys as the	ledical	22	_ a								
ath cer	uttendir or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pregnanc	у			23d. Date of de Month	livery Day Year
the de	y the a	ysic	1 □ Yes 2 🖾 No 9 □ Unknown	4 ☐ Pregnant g ☐ Unknown	at time of death	5 L	Other (specify)					
s that	gned b	by Pt	Part II. Other significant condition		out not resulting	in the u	nderlying cause give	en in Part I.				o the cause of death?
require	een si nould l		Atrial fibr	rillation								robably 4 🗆 Unknown
he law	e has b ige 2 sl	Completed								opsy ormed?	prior to death?	utopsy findings available completion of cause of
ian: T	rtificat tor, pa	Be	25. Was case referred to medical					26. Place of Deat	1 □ Yes th (Check only			sted Living
hysic	this ce al direk	ဥ	examiner? 1 Yes 2550		ient 2 ER/C	Outpatier Time o		4 L Nursing Ho	ome 5 ☐ Res		6 ∑ ther (Spe	-
ding	After funer	tion	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)		Injury	Worl	yal (? Yes 2 □ No	28d. Describe	now inju	iry occurred	
r Atter	rector by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	20e. Flace of It	jury - At home, f tc. (Specify)	arm, str	eet, factory, office		28f. Location City or To	(Street a wn, Stat	nd Number or Fi	lural Route Number,
pitalo	To the Funcial Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	1 1	29a, Certifier 1 Certifying	Physician: To the bes	t of my knowledg	ge, deat	h occurred at the tin	me, date and place	, and due to the	e cause(s) and manner a	as stated.
ne Hos	ne Fun pletely	29a. Certifier (Check only one) 2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								e to the cause(s)		
70 tt	To the com	29b. Signature and title of certifier 29c. License number D0025499 29d. Date signed (Month, Day, Year) 12/21/2009										
			30. Name and address of person w	ho completed cause of	death (Item 23a) (Type	Print)					
	12W		James Ruppel,	MD 1460 I	Ritchie		hway Arn	old, Mary	yland	2101	2	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 23	2009 32. Regis	trar's Signature	A	hared					
	9,01		72440	June	p.	19	200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Marylar		artment of H			iene 	43168
I	Physicia	an	1. Decedent's Name (First, Middle, Last Lula	Mae	Vassa:	110		2. Date of Deat Month Decemb	Day Year er 11, 200	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give Allegany Co Nursi		nter	4b. City, Town, or Cumber	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Se 218-16-3506	x 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05 / 18 / 1	Year) C	rthplace (State or Foreign country) Maryland
	ryland how		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	the Ma 28a-f s	ecto	MD Alle	gany		umberland		1	Og. Citizen of What C	1 ∑ Yes 2 ☐ No country?
	23a or	ral Di	219 Springdale S	Street, Apt 2		2	1502		USA	
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 8ne. than "	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired Homemake	during most of won d)		16b. Kind of Busines Home	·
Maryland 2	should be filed and Mental Hygi markad other matic evant, I	To Be C	17. Father's Name (First, Middle, Last) Oliver	George	Aldride	ge		ne <i>(First, Middle, I</i> Elizabeth		lla Easton
Mary	2 PE 88 11		19a. Informant's Name/Relationship (T)						City or Town, State,	
20a. Method of Disposition Commercial Service Disposition Date								Date	d MD 215 20c. Location - City o Cumberlat	r Town, State
								ams Fami	ly Funeral	
	23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition a. Pohalu Coronary artery Dis							or respiratory arm		Approximate Interval Between Onset and Death J - 4M
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	0	1			
	ed sit	Sequentially list conditions, Due to or as a consequence of): cause. Enter Underlying								
68760,	Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C									
.O. Box 68	death certific e attending p ed for use as i	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of d Month	elivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									to the cause of death? Probably 4 Minknown	
Il Record	. The law requires cate has been sign page 2 should be	Completed						24a. Was a autops perform	sy prior to	autopsy findings available o completion of cause of es 2 \(\sum \) No
1 Yes 2 No Yes N									pecify)	
n of		on: T	27. Manner of Death 1 UNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur			ow injury occurred	,,
Division	E E :: 0	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, st		Tes 2 No	28f. Location (S. City or Town	treet and Number or i n, State)	Rural Route Number,
1	To the Hospital or Atta within 24 hours after de To the Funaral Directo completely filled in by th	edical Co	29a. Certifier 1 Certifying Phyone) Certifying Phyone 2 Medical Example 1	ysician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, deal	h occurred at the ti- vestigation, in my o	me, date and place opinion, death occu	, and due to the c irred at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certified	-ph		29c. Licens	se number	2	Ped. Date signed (Mo	
	N DOS		30. Name and address of person who described the Sunil K. Gu		_{em 23a) (Type} 625 Ker			Land, MD	21502	***
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 4 2009	32. Registrar's Sign	fart.	and the same				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Jamar Kenan Williams 25, 2009 December 19:25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/25/2009 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 1 X M 2 □ F Days Months Hours MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's 1 X Yes 2 ☐ No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9711 Jacqueline Drive 20744 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc 1 X Never Married 2 ☐ Married Specify: Black 1 □Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jay A. Williams_ Jr. Keisha N. Daniels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay A. Williams, Jr./Father 4619 Birchtree Lane, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory: 12/29/2009 Beltsville 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Strickland Funeral Services Topic 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

Physician /Medical Examiner

> as nse

for

signed by the a

has page 2

in by the funeral director,

Certification: To

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27.

DEC 3 1 2009

The law requires that the death certificate be executed

Box 68760

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Division of Vital Records,

Hospital or Attending Physician:

24 hours after death Funeral Director:

To the within 2

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than amy injury or other traumatic event, In and once.

Physician

/Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f si event, the Medical Examinar is ust by notified

altimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last and burial-trar attending physician

disease or condition resulting in death)

Extreme prematurity Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery

3 🗆 Ectopic pregnancy

Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions of þ Completed Be 25.

4 ☐ Pregnant at time of death	5 Other (specify)
9 ☐ Unknown	
ontributing to death but not resulting in the	he underlying cause given

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

1 🗆 Yes

2 🗆 No

Month

				I L Tes
Was case referred to medical examiner?			26. Place of De	ath (Check only or
1 Yes 2 X No	Hospital: 1 X Inpatient 2	ER/Outpatient 3 □ D	OOA Other: 4 Nursing H	-lome 5 ☐ Resid
Manner of Death 1 XX Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)		28c. Injury at Work?	28d. Describe h

dence 6 Other (Specify) now injury occurred

in Part I

2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd., Silver Spring, MD Mary Lenore Keszler 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Dec. 18, Whitfield 2009 9:01A Charles Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2708 Summerview Way, Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 1 🕅 M 2 □ F 83 Months Days Hours 0 77 1926 ar Kentucky Director 402-22-6683 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2708 Summerview Way #103 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Retired
If Yes, Give 1069 P Black, White, etc. Completed by 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Year or Dates. 1968 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) US Marine Corps Military other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) H.E. Whitfield Ruth Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita L. Whitfield/Wife 2708 Summerview Way, #103, Annapolis, MD. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ឺ Burial 2 🗌 Cremation 3 🗌 Remoyal from State Arlington Nat. Cemetery 2/25/2010 Arlington, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home ale 2973 Solomons Island Rd. Edgewater, MD21037 23a. P. 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on- cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cerebravaschlar Medical Due to (or as a consequence of) Examiner years Sequentially list conditions, if any leading to in necial cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed attending physician and for use as the burial-transit perligidemia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 🗆 No the 9 Unknown 9 Unknown i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician; The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Box 68760

Division of Vital Records,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

3169

29c. License number

ZOI

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All'Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Samue Month Day **Physician** Wat 2009 Deci13 /Medical mot institution

Klagg Cumher Je. Sex

1 M 2 F 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Burnie Apt. 103 Anne Glen 7. Age (In yrs. last birthday)

5 6 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months **Director** Marylano Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show 1 PYes 2 □ No Director en 10e. Street and Number 10g. Citizen of What Country? Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ Ño Specify: Black Specify. 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, Ire IV. College (1-4or 5+) City Government rounds 10 Keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Groce Stevens Helen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Apt. 103-6 len Burnie, Watkins-Hawkins atherine 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chester Cometery hester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
1+ewry Funero 21. Signature of Funeral Service Licensee Henry Funeral 1. 510 Washington St. derry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for I in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 TUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No this certificate 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

29b. Signature and title of certifier

Name and address of r

Year)

31. Date filed (Month, Day,

rson vito completed cause of death (Item 23a) (Type Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Dr. ViJay

31. Date filed (Month, Day, Year)

201 Hall Highway Crisfield, Maryland 21817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Karumbunathan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Jeffery Lee Wheeler 2009 December 7:17 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester 510 Taylors Island Road Taylors Island 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs._ 8. Date of Birth (Month, Day, Year) May 8, 1954 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**X** M 2 □ F Maryland 217-64-7092 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Marylar r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Dorchester Taylors Island Director 1 ∐Yes 2 ∐XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Taylors Island Road USA 21669 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 221 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc nours after 1 Never Married 2 Married 1 □Yes 2 🛣 No Specify <u>چ</u> white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) owner construction s 1 and 2 should be filed wind Health and Mental Hygier item 27 is marked other the other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth L. Wheeler Sr. Dorothy Castranda ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth L. Wheeler Jr. brother 13893 Forsythe Road, Sykesville, MD 21784 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Crematory of Delmarva: 12/21/09 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** pertensive Covonary Vascular unknown disease or condition resulting in death) /Medical **Examiner** tension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of). attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 1 ☐Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☑ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Year) State

Registrar
DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month John Willis Webb December 2009 11:35a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2247 Wingate Bishops Head Road Wingate Dorchester 8. Date of Birth (Month, Day, Ye Jan. 27, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign ^{Year)} 1941 1 ☑ M 2 □ F Months Days Hours Mary Land 68 215-38-1213 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Wingate 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2247 Wingate Bishops Head Road 21675 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No white Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marine services maintenance 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey O. Webb Ella Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Webb wife 2247 Wingate Bishops Head Rd., Wingate, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/09 Cambridge, MD Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastahic Immediate Cause (Final Camiley disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □ Yes 2 Ne 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner and burial-tra attending physician as asn for

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show "natural", or items 23a or 28a-f show

than "

Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Impone.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Completed

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Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed the page 2 should certificate funeral director. this After within 24 hours after death To the Funeral Director: filled in by the

Division of Vital Records, P.O. Box 68760,

State

4 ☐ Homicide

(Check only

31. Date filed (Month.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANW

29a, Certifier

503 BYRN

32. Registrar's Signature

1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D47924

ST CAMBRIDGE MD 21613

29d. Date signed (Month, Day, Year)

12-17-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:58 A December 18, 2009 Richard Paul Winter, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Shady Side Anne Arundel 1601 Snug Harbor Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days 02/04/1944 Washington, 65 577-56-5232 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No Maryland Shady Side Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20764 1601 Snug Harbor Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Television Repair Owner 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Rithman Joseph Winter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1601 Snug Harbor Rd., Shady Side, MD 20764 Mary Ann Winter/ Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-20-2009 Kalas Crematory Edgewater, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 26 mus disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐Yes 22 No 26. Place of Death (Check only one)

Box 68760, P.O. Division of Vital Records,

Examiner law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria signed by the a cate has been signated by page 2 should b Hospital or Attending Physician: The this certificate funeral director, death. e Funeral Director

letely filled n by the fi To the within 2

/Medical Examiner Physician/Medical 2 Completed Be Certification: To Medical completely

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be multilled at once.

Physician

altimore, Maryland 21215-0036

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 9 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation 6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRSTGATE DO PANAMIO M

31. Date filed (Month, Day, Year)

DEC

32. Registrar's Signature

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24, JOHN DAVID WAGONER DECEMBER 2009 14:04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WMHS - REGIONAL MEDICAL CENTER ALLEGANY CUMBERLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6 Sex 8. Date of Birth **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs WEST VIRGINIA Director 232-72-9642 65 08/17/1944 Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits show s 23a or 28a-f shortured at Director WW FORT ASHBY 1 ☐Yes 2X No MINERAL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 86, BOX 146 26719 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or items 11. Marital Status Affiled Forces: 1 **X**Yes 2 □ No If Yes, Give Year or Dates: **'64-'66** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) KELLY-SPRINGFIELD Elementary/Secondary (0-12) 12 TIRE COMPANY Z & M SHEET College (1-4or 5+) TIRE BUILDER 2) SAWMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Ith and Mental 27 is marked o traumatic eve permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic events. JOHN H. WAGONER, JR. EVELYN GRACE SISK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID TROY WAGONER / SON 1908 BEDFORD STREET, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ORT ASHBY CEMETERY 12/29/2009 FORT ASHBY, WV 22. Name end Address of Facility
UPCHURCH FUNERAL HOME, Signature of Funeral Service INC. 4) Chelic P.O. BOX 1260, FORT ASHBY, WV 26719 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiogenic Shock /Medical Due to (or as a consequence of): Examiner 4 hours Ruptured Papillary Muscle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed 36 hours Recent M.I. attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 Yes 2 No After this certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1+ Natural 5 Pending neral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral C 1🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number DECEMBER 24, 2009 D67309 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVAN ZIMMER, M.D., WMHS MEDICAL ARTS BLDG., SUITE 330, CUMBERLAND, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 DEC 2009

DHMH 17 Rev 1/2001

Registrar

09-10134 Lauri Waqqoner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Lauri vvaggorier	1- For State Certificate Registrar State of Maryland / Department Certificate		Reg. No. 20	09 43177			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Laurie Ann Marie	Waggoner	2. Date of Death Month Day Yea December 27, 2009	3. Time of Death 1244 hrs			
	Facility Name (if not institution, give street and number) G363 Oxon Hill Road	4b. City, Town, or Location of Dea Oxon Hill	th 4c. County	4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		rs. 8. Date of Birth(MM/DD/YYYY				
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo N/A Was	ocation Shington		10d. Inside City Limits 1 X Yes 2 No			
the Maryland or 28a-f sh tified at once	10e. Street and Number 613 Eastern Avenue	10f. Zip Code 20019	10g. Citizen of Wi				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.) White	e - American Indian, Black, e, etc.			
5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Yes 2 X No specify: dent's Usual Occupation (Give kind of g most of working life. DO NOT use re	Specify: f work done 16b. Kind of Bu	White usiness/Industry			
-003(I within giene. her that the Medic	12 17. Father's Name (First, Middle, Last)	Waitress 18 Mathed's Nam	Res	taurant			
1215. I be filed ental Hy urked or vent, th	Michael Leroy Waggor	ner Karen	Sue	Hebb			
AD 21 2 should h and Me 27 is ma matic ev		iling Address (Street and Number or 04 Bartsonville Ro					
imore, N Pages I and nent of Health ant: If item or other trau	20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other Specify: 20b. Place of Disposition Crematory of Mt. Tabo	position (Name of cemetery, other place) or Cemetery 12	Date 20c. Location -	Own, MD			
Balt permit. Departr Import injury	21. Agridure of Funeral Pervice Licensee 22	2. Name and Address of Facility Av 404 Decatur Stree					
Physician /Medical Examiner	23a. Part N. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Sharp Force Injuries	er the mode of dying, such as cardiac	or respiratory arrest, shock, or hea	Approximate Interval Between Onset and Death			
<u> </u>	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Cisses or injury the initiated cause)						
cuted and transit	events resulting in death) Last Due to (or as a consequence of): d						
60, ate be executed hysician and e burial - transit	UNPENDED AMENDED F. FEMALE: 23c, If yes, outcome of pregnancy.						
ox 687 ath certifice attending p or use as th	23b Was decedent pregnant in the	Fetal death 3 Ectopic pregn Other (Specify)	23d. Date of Month	delivery Day Year			
, P.O. Bores that the designed by the bedetached for detached for deta	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I	23e. Did tobacco use contril	bute to the cause of death? Probably 4 Unknown			
of Vital Records, ig Physician: The law requires the this certificate has been sig- meral director, page 2 should be To Be Completed			autopsy p performed? d	Vere autopsy findings available rior to completion of cause of leath? Yes 2 No			
	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)				
on of Vital ending Physician: ath. or: After this certif the funeral director, ttion: To Be (1 V Yes 2 No 27. Manner of Death 28a, Date of Injury 28b, Time of		ng Home 5 Residence 6 v 28d Describe how injury occurre				
ion trendir death. tror: A	1 Natural 5 Pending FOUND: Dec 27, 2009 FOUND: 1226 hrs	1 Yes 2 ✔ No	Subject assaulted				
Division o Hospital or Attending 24 hours after death. Funeral Director: Aft tely filled in by the fune al Certification:	3 Suicide 6 Could not be determined (Specify) Hotel/Motel	reet, factory, office building, etc.	28f. Location (Street and Number or Town, State) 6363 Oxon Hill Road, Oxon				
Fo the Ho within 24 F To the Fu completely	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
W.	29b. Signature and title of certifier Covade Halla	29c. License number O.C.M.E.	29d. Date signe December 2	ed (Month, Day, Year) 28, 2009			
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registrar	31. Date filed (Month, Day, Year) DEC 30 2009 32. Fegistrar's Signature	ules					

DHMH 17 Rev 1/2001 OCME 2006 09-10163 Solei Watson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Solei Watson		1- For State Registrar	e of Maryland		artment o ertificate o		d Mental H	-	Reg. No. 20	09	43178
Physician/ Medical Examiner		Decedent's Name (First, Middle, I Solei Amir W						2. Date of Dea Month	ath Day Year er 28, 2009		Time of Death 1815 hrs
		4a. Facility Name (if not institution,)		4b. City, Town, or I	Location of Death		4c. County o	f Death	
		John Hopkins Hospital				Baltimore			Balt		
Funeral Director		5. Social Security Number 6. 213-59-0916			last birthday) Yr:	Months Days		B. Date of Bi	irth(MM/DD/YYYY) - 2000		ace (State or y)MD
, u	L	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loca	tion				10	d. Inside City Limits
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Maryland 28a-f show any d at once.	Director	10e. Street and Number			1110000	10f. Zip Code		1	10g. Citizen of Wh	at Country	?
n the N 3a or	l Dir	11410 Bratte	n Ave, Ar	t 1:	3	21853		τ	J.S.A.		
th with	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Deceden	t Ever in U	J.S. 13, W	as Decedent of Hisp es, specify Cuban,		ecify Yes or No			Indian, Black,
ter dea		3 Wildowed 4 Divorced III Yes Give Year 11 Voc 2 Y No specific					SpecifyBlack				
ours af atural	d by	15. Decedent's Education (Specify	or Dates:	npleted)		nt's Usual Occupation	on (Give kind of w		16b. Kind of Bus		stry
16 n 72 h an "n ical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)		nost of working life.	DO NOT use retir	ed)	C+34	L	
5-003 Hed withi Hygiene. Jother th	mo;	17. Father's Name (First, Middle, La	st)		None	<u> </u>	B Mother's Name	(First Middle	Student Maiden Surname)	-	
21215-0036 Juid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Be	Tavon Watson	,			,	Vomika	Dicker	rson		
21 should nd Me is man	ပို	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or R	tural Route Nur	mber, City or Town	, State, Zip	Code) 21853
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f sher traumatic event, the Medical Examiner must be notified at once		Yomika Dicke	rson/Moth	er 20b.	Place of Dispos	0 Bratte sition (Name of cem	en Ave,	Apt 1	3, Princ	Cess	Anne, MD
		1 X Burial 2 Cremation		ate	crematory or ot	her place)	<i>"</i>			•	
Baltimore, permit. Pages I as Department of Hee Important: If ite		4 Donation 5 Other Speci 21. Signature of Funeral Service Lice		Sc	<u>22.1</u>	S UMC C	of Facility 917	W . T	Pocomo	st.	<u> </u>
	0	Tursell I	al		Be Fu	nnie Sm neral He	ome Sal	isbury	y, MD 2	1801	- 1
Physician		23a. Part Enter the disease, or cor failure. List only one cause on	each line.		n. Do not enter t	he mode of dying, s	such as cardiac or	respiratory arr	est, shock, or hear	rt A	pproximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Metastati Due to (or as a cons			fibrosar	coma				Death
_		Sequentially list conditions,	b								
	nine	if any, leading to immediate Due to (or as a consequence of): couse. Energy Underlying Couse Chicago as inherity to the course.									
50, te be executed ysician and burial - transit	I Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons d.	equence o	of):						
O, e be executed ysician and burial - transi	edical	X UNPENDED	AMENDED 3a, 2	7,pe	rmE, g9	00 2/1/10	TT				
Sion of Vital Records, P.O. Box 6876(Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phy. by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom		nancy	tal death 3	Ectopic pregnar	ncv	23d. Date of d Month	lelivery Day	Year
Box 6876(The death certificate the attending phy and for use as the b	Physician/M	past 12 months? 1 Yes 2 V No 9 Unknow	Pregnant at	time of		ner (Specify)				,	
O. Be t the de by the a	Phy	Part II. Other significant conditions	9 Unknown	n but not r	esulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	ute to the	cause of death?
ires that the signed by	d by							1 Yes	2 No 3	Probably	4 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed							24a. Was			y findings available
tal Reco	mo							perfor		ath? ✓ Yes	2 No
Vital F ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check o				
of Vi ing Physi After this uneral dir	ျ	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatient 28b. Time of I				Residence 6 how injury occurred	Other:	
ion of tending Ph eath. or: After the funeral	ţi	1 X Natural 5 Pending	(Month, Day,Y	ear)			es 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division tal or Attendii rs after death. al Director:	ertification:	2 Accident Investiga 3 Suicide 6 Could no	29a Pinga of In	jury - At h	I ome, farm, stree	et, factory, office bui	ilding, etc.		Street and Number	or Rural F	Route Number, City
Divi	S	4 Homicide determined (Specify)									
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only Certifying Physi	cian: To the best of m er:On the basis of exa		-						u s e(s)
To To con	Mec	29b. Signature and title of certifier	and manner stated.			29c. License	number		29d. Date signed	(Month, I	Day, Year)
		Catorle	ens			O.C.M	l.E.		December 2	9, 2009	
	f	30 Name and address of person who		,	,	Chrost Date	ere MD 0400	14			
	ate		stant Medical Exa			Street, Baltime	ore, MD 2120	J1			
Regist	rar	31. Date filed (Month, Day Year)	2010 32. Registra	ما الاداد	D. 100	-					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year O Physician/ Month Day 2 David Edward West 1034 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** regional Jicomico 8. Date of Birth (Month, Day, Year) May 9, 1954 9. Birthplace (State or Foreign **Funeral** 1 ₺ M 2 🗆 F Months Hours Mary Land Director 55 219-46-4501 Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director 1 🗌 Yes 2 🔀 No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32770 Roy West Road 21875 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event the Medicine. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent ____ Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XX No Specify: 3 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Poultry Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Evelyn E. Shockley Roy E. West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32770 Roy West Road Delmar, MD Ruby Alice West 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Dec. 31, 2009 Delmar, Maryland Cemetery Melsons eture of Funeral Service Licensee Name and Address of Facility
hort Funeral Home
3 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCUO disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see of injury) Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year Month Day the a P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HW Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b lirector, page 2 s autopsy performed? Yes 2 2 death? completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗹 Yes Other: 2 🗌 No 1 Inpatient 2 WER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ANatural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of ce 29c. License number 28/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 mg Chris E 31. Date filed (Month strar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elnora White 2009 02:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SHUSBUR HIOMICO 8. Date of Birth
(Month, Day, Year)
7 – 1 2 – 1 9 2 If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 🔀 F Country) 88 Director 229-09-4670 192 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD1 X Yes 2 No Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Newtowne Apt 21851 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 ☐ Divorced Specify Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Newtowne Apts. Assistant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Brown Mary Ann Wallop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie Collins/Niece Brantley Rd, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) M 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Mt. Sinia Baptist 12-26-2009 Pocomoke City, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician 1 Medicai resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence or, Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending humanian and Cause (Disease or linjury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a nd title 29c. License number

State Registrar 30. Name and address

31. Date filed (Mont

Chris

100 E. CA

o completed cause of death (Item 23a) (Type, Print)

istrar's Signature

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Yeager Esther Lee 12:36 PM December 28 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Lions Ctr for Rehab and Ext Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 89 Maryland Director 212-18-1576 05/20/1920 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanable must be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** MD Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 12401 Bowling Street, SW 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sourbaugh Bertie William Thomas ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12401 Bowling Street, SW, Cumberland, MD Linda Yarnall / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1:
Department of He
Important: If iten
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem. Gardens 12/31/2009 LaVale, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALZHEIMER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ GIBRILLATIONS 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed certificate 1 ☐ Yes 2 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the 1 within 2 To the 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier UFCEMPER 29 2009 D0026907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walsh Rd, Cumberland MD 21502 Harjit Sidhu 925 Bishop 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Veager,

			For State Registrar	State of Ma	ryland / Depa	artment of F			711119	43182	
	Physicia		Decedent's Name (First, Middle, Las James	Cortes	***	Zembower	<u>Joann</u>	2. Date of Deat	h Par Year	3. Time of Death 2223 M	
 	Medio Examir ∤		4a. Facility Name (if not institution, give Western MD Regio	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or	r Location of Deat		4c. County of Dea	ath	
	Funeral Director		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	year) 9. Bi	rthplace (State or Foreign	
			Usual Residence of Decedent		01			1 04/25/1	928 I M	arýland	
	ryland -f sho ied at	Director	10a. State 10b. County MD Alle		10c. City, Town or Lo	cation Cumberla:	m d			10d. Inside City Limits	
	he Ma or 28a i notif	Dire	MD Alle 10e. Street and Number	gany		10f. Zip Code	nu -	0g. Citizen of What C	1 🗆 Yes 2 💢 No		
	12907 Bedford Road, NE 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent							21502 USA			
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates.	lo l'	Was Decedent of H f Yes, specify Cuba ☐ Yes 2 🟋 No	ın, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	vithin 72 hou iene. ir than "natu the Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5+	(Give I life. Do	dent's Usual Occup kind of work done o O NOT use retired) echanic		rking	16b. Kind of Business	ŕ	
/land	d be filed w Mental Hyg arked othe ttic event,	To Be	17. Father's Name (First, Middle, Last)	alvin	Zembo		18. Mother's Na Thelma	me (First, Middle, M Berna	laiden Surname)	Casecamp	
, Man	The state of the s								•	. ,	
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	e) cory 12/		20c. Location - City o Cumberlar					
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Lisens						ly Funeral rland, MD	Home, P.A. 21502	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								st,	Approximate Interval Between Onset and Death		
	Examiner	۲	resulting in death) Sequentially list conditions,	Due to (or as a	consequence of):						
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09	icate be executed g physician and is the burial-transit	dical E	resulting in death) Last	d	consequence of):						
876	tificat ing phi e as th	Med	IF FEMALE:						_		
P.O. Box 687	or Attending Priysician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year	
ds, P.C	v requires that is been signed be should be deta	ed by P	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?	
Division of Vital Records,	sician: The law red certificate has ber irector, page 2 sho	Completed						24a. Was an autops perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of	
ta .	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che				
<u> </u>	Physic rthis c ral dir	3: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatien 28a, Date of injury	t 2 ER/Outpatien	t 3 DOA Othe	4 ☐ Nursing F		nce 6 Other (Spec	cify)	
ouo	ath. r: After	28b. Ime of Late of Injury at work? 1 Accident Investigation 28b. Ime of injury at work? 28b. Injury at work? 1 28b. Injury at work? 28b. Injury at work?									
Division	re hospital or Attending Priysion 24 hours after death. The Funeral Director. After this copleted filled in by the funeral director.	I Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (r - At home, farm, stre (Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,	
	io the Hospit within 24 hour To the Funers completed fills	Medical	(Check 2 Medical Exami	sician: To the best of moner: On the basis of exame Practioner: To the be	mination and/or investi	gation, in my opinio	 n. death occurred : 	at the time, date and	place, and due to the	cause(s) and manner stated.	
1	2+		29b, Signature and title of cartifier			29c. License	number 3 2 8 0		Dec 14,		
	1223		30. Name and address of person who c Sunil K	ompleted cause of dea Gupta, M.	th (Item 23a) (Type, Pi . D., 625 K	rint)					
	Stat Registra	e ir	31. Date Flee Chorth, Day 2009	32 Pagistraria	Signature	·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPt1,11 per me, g90,02/04/2010dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 21, 2009 MATTIE JARMAN ANTHONY 7:30 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min JUNE 16 1905 104 MARYTAND **Director** 212-16-7024 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2X No QUEEN ANNE'S CENTREVILLE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 152 CAVALRY COURT 21617 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give "natural", 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRINCIPAL **EDUCATION** be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM AMOS JARMAN LYDIA VIRGINIA SMITH t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY LEE JACKSON/DAUGHTER 202 SPANIARD NECK ROAD, CENTREVILLE, MD 21617 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) DEC. Date 28 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 XBurial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY 4 Donation 5 Other (Specify) 2009 CENTREVILLE, MD Signature of Funeral Service Licen FENTOWS, GOTTE FENBEIN & NEWNAM FUNERAL HOME, 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cardiomyopathy Physician/ disease or condition resulting in death) Medical Due to (or Atherøsc#erosis Examiner Sequentially list conditions, Examine if any, leading to immediate

Cause (Disease or iinjury Peripheral Vascular Disease years Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran POROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical CERTIFICATION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnanτ a 9 ☐ Unknown been signed by the sale should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an tor: After this certificate has the funeral director, page 2 s performed Yes 2 1 Yes 2 No Be 25. Was case referrexaminer? 26. Place of Death (Check only one) Hospital Other: 4X Nursing Home 5 - Residence 6 - Other (Specify, 1 X Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License numbe

State Registrar 31. Date filed

30. Name and address of person who completed

(Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 18 2009 William Port Anderson 9:56A M December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1160 Harvard Road Charles Waldorf If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F Months Days Hours Min. 235-70-6538 64 May 27, 1945 West Virginia Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1160 Harvard Road 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Engineer</u> Wholesaler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charley J. Anderson Belva Buella Smoot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice E. Anderson/Wife 1160 Harvard Road, Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec.22,2009 Huntt Crematory Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home auch 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3035 Old Washington Rd. Waldorf, MD 20601 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary artery sears Due to (or as a consequence of): per lindemen Sequentially list conditions, if any leading underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Director

Completed by Funeral

Be

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Examiner

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at

Health and Mental Hygiene. em 27 is marked other than

Department of Health Important; If item 27

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injury

be

Baltimore, Maryland 21215-0036

and attending physician the nse 'n the ģ signed t has

Exami

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Certification:

Medical

page 2 certificate this After

executed Box 68760 requires that the death certificate be Physician/Medical Ö σ. Records, Completed Division of Vital Hospital or Attending Physician: death. after death Director; / d in by the f n 24 hours aft e **Funeral Di** iletely filled ir To the I within 2 To the I

State Registrar 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 1 □Yes 2 □ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARNER CASTRENTE OLD LINE CENTER (2070 319 low CUTIPORF, MD 20602

72/00

32. Registrar's Simature

			For State Registrar	State of Maryland / De		Health and M	lental Hygi	•	
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last Zulay Elizabeth	•			2. Date of Death Decembe	r 26, 2009	3. Time of Death 11:05 AM
	Examin		4a. Facility Name (if not institution, give s Shady Grove Adver		4b. City, Town, o	or Location of Death		4c. County of Deat	
	Funeral Director		213 27 3117	x ☐ M 2 🖫 7. Age (In yrs. last birthday 42 Yrs.	Months Days		8. Date of Birth June 10	year) ,1967 Ecu	hplace (State or Foreign untry) ador
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	MD Montgome 10e. Street and Number	ery Gaithe	Location ersburg 10f. Zip Code		- 1	0g. Citizen of What Co	10d. Inside City Limits 1
	h with t ns 23a nust be	neral	202 Sunny Brook	Terrace #638	208	377		United Sta	-
9036	rs after deat ıral", or iten Examiner r		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Hispanic Origin? (Spectan, Mexican, Puerto Formal) Specify: Ecua		14. Race - Ame Black, White Specify: Whi	e, etc.
Maryland 21215-0036	vithin 72 hour jiene. er than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12) 12	de completed) (Giv	redent's Usual Occu re kind of work done DO NOT use retired PTK	during most of working	ng	16b. Kind of Business Retail Sal	
yland 2	ld be filed w Mental Hygi larked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Jacinto N. Andrae	de		1	me (First, Middle, Maiden Surname) B. Flores		
, Mar	nd 2 shou lealth and m 27 is m her traum		19a. Informant's Name/Relationship (Type Fernando Andrade	City or Town, State, Zip					
Baltimore,	Page 1 a tment of H tant: If ite jury or ott		20a. Method of Disposition 1 😾 Burial 2 🗌 Cremation 3 🗍 4 🗎 Donation 5 🗍 Other (Specify)	Removal from State cemetery, cr All Sou	position (Name of rematory or other plants commete 1s Cemete	ry 2009	30,	20c. Location - City or Germantown	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Ligence	QM		^{ess of Facility} DeV Deer Park		al Home hersburg,	MD 20877
	Physician/ Medical Examiner e private transit	ical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to a manufacture of the cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	ilication that caused the death. Do not elected the caused the death. Do not elected that caused the death. Do not elected that caused the death. Do not elected that caused the caused that caused th	er	ng, such as cardiac of	respiratory arres	,	Approximate Interval Between Onset and Death 36 HRS
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the topical process.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		☐ Ectopic pregnan	псу		23d. Date of del Month	ivery Day Year
s, P.O.	ires that th signed by Id be detac	d by Pr	Part II. Other significant conditions con	ntributing to death but not resulting in the	e underlying cause g	iven in Part I.		acco use contribute to	the cause of death?
Record	he law require has beer vage 2 shou	omplete					24a. Was an autopsy perform	/ prior to d	copsy findings available completion of cause of
tal	cian; T	Be	25. Was case referred to medical examiner?	Hospital:		Place of Death (Check		LEATO 1 TO TOO	
of Vi	g Physi er this c eral dir	e: 10	27. Manner of Death	1 X Inpatient 2 ER/Outpati	of 28c. Inju	ry at 2	ne 5 Resider	nce 6 Other (Speci v injury occurred	fy)
Division of Vital Records,	al or Attendin s after death. Il Director: Aft ed in by the fun	Medical Certificate:	1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year) injury 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 🗆	Yes 2 No	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
_	the Hospit nin 24 hour the Funera npleted fills		(Check 2 Medical Examin only one) 3 Certifying Nurse	cian: To the best of my knowledge, death ier: On the basis of examination and/or inve e Practioner: To the best of my knowledge	estigation, in my opin	ion, death occurred at	the time, date and	place, and due to the o	ause(s) and manner stated
•	Owith Court		29b. Signature and title of certifier	Wille		se number 59336		ecember 26	
			30. Name/and address of person who co Dr. Janelle Willi	completed cause of death (Item 23a) (Type) Lams M.D. $9901~{ m Me}$		nter Drive	, Rockvi	.11e, MD 20	850
	Stat		31. Date filed (Month, Day, Year)	32 Registrar's Signature	arked		<u> </u>		

DHMH 17 Rev 7/2009

Dhusisian
Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middol Evan that it ust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Regist

	1 - For State Registrar	Certifica	te of Death	Reg	2009	43186					
	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death					
ian cal	Helen Ogle Atkins				25, 2009	8:25 Ам					
ner	4a. Facility Name (If not institution, give street and number)	4b. City	, Town, or Location of Dea	th	4c. County of Dea	th					
	Gentle Steps Assisted Living		iverdale		Prince Georges						
	5. Social Security Number 6. Sex 7. Age (In yrs. las	Months	er 1 Year If Under 24 Hrs Days Hours Min	. (Month, Day, \		thplace (State or Foreign ountry)					
	578-62-1302	Yrs.		Feb.19,	1908 N∈	w York					
	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location				10d. Inside City Limits					
5						1 Tyyes 2 □ No					
ect	Md. Montgomery Si	lver Spri	ng ip Code	100	g. Citizen of What Co	untry?					
Funeral Director											
era	5 Shannon Court 11 Marital Status 12. Was Decedent Ever in U.S.		20904	Specify Yes or No-	U.S.A	erican Indian					
ᇤ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	If Yes, sp	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	rto Rican, etc.)	Black, Whit	nite, etc.					
Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busine (Specify only highest grade completed) (Give kind of work done during most of working										
lg l	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)										
5	4	Elementa	ry School Te	acher	Education	1					
Be (17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Ma	iden Surname)						
2	Robert Harold Ogle		Helen	Freeman M	oore						
	19a. Informant's Name/Relationship (Type. Print) / Daughter	19b. Mailing Addres	ss (Street and Number or F	Rural Route Number, (City or Town, State,	Zip Code)					
	Melanie Atkins Anderson		n Court, Silv								
	20a. Method of Disposition 20b. Pla 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	nce of Disposition (Na metery, crematory or Ount Oliv	ame of other place) De c	Date 20	Oc. Location - City or	Town, State					
	4 Donation 5 Other (Specify)	emeterv	20	009 W	ashington	, D.C.					
	21. Signature of Funeral Service Licensee M0021	22 Name a	and Address of Facility	DeVol Fune	ral Home						
	Henry S. Fort		Wisconsin Av	e. N.W., W	ashington	,D.C.20007					
	23a. Part 1. Enter the discrete, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mo	ode of dying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between Onset and Death					
	Immediate Cause (Final										
	disease or condition resulting in death) a. Failure To Thrive Due to (or as a consequence of):										
	Atheroscle	rosis				Years					
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. Advanced As	ence of):									
am	Cause (Disease or injury that initiated events resulting in death) Last					Years					
<u> </u>	resulting in death) Last Due to (or as a conseque	ence of):									
Medical Examiner	d										
	IF FEMALE:										
ian/	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic			23d. Date of de Month	livery Day Year					
Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	ath 5 ☐ Other (s	specify)								
	Part II. Other significant conditions contributing to death but not resulti	ting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?					
Completed by		, ,		1 □ Yes	2 1 No 3 □ P	robably 4 Unknown					
etec											
d d		_		24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of					
ပ္ပ				1 □ Yes 2	No 1 □ Ye	2 □ No					
æ	25. Was case referred to medical examiner? Hospital: Hospital:		0.11	eath (Check only one)		Assisted					
<u>٩</u>	1 Tes 22 No 1 Inpatient 2 E	R/Outpatient 3 28b. Time of	DOA 4 Nursing	Home 5 Residen		ecify)L1V1ng					
ion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred						
ica	3 Suicide 6 Could not be See Bloop of Injury. At hom			28f. Location (Stre	eet and Number or Fi	ural Route Number.					
i.	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	, , omoo	City or Town,							
Medical Certification: To	29a. Certifier 1⊠ Certifying Physician: To the best of my knowl	ledge, death occurre	ed at the time, date and pla	ce, and due to the ca	use(s) and manner a	is stated.					
dic	(Check only 2 Medical Exeminer: On the basis of examination one) and manner stated.										
Me	29b. Signature and title of certifier	2	9c. License number	29	d. Date signed (Mon	th, Day, Year)					
	TOO LIND MAA		D31319	Do	cember 28	2009					
	30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)	עונונע	שם	CEMPET 70	, 2003					
	Loreto S. Albiol, M.D. 8218	Wisconsin	Ave. #305, 1	Bethesda,	Maryland	20814					
ate	31. Date filed (Month, Day, Year) 32 Registrar's Signatu	banks.	3								
rar	DEC 2.9 2009 1/2 Nove 4	BRUKE	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#3perME, G899, 1/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** December 31, 2009 John Broady 1825 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4473 23rd Parkway #304 Temple Hills Prince George If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 ₩ M 2 □ F 62 Yrs Director 579-64-5014 Aug 28, 1947 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ıral", or items 23a or 28a-f show I Examiner must be notified at 1x Yes 2 No Directo Maryland Prince George Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4473 23rd Parkway #304 20748 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: **Black** 3 ☐ Widowed 4x Divorced 'natural" traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any Injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Twe1th Special Police Officer Private None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Edward Broady Cornelia Stokes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3321 Huntley Square Dr #T-2, Temple Hills MD 20748 Sheree Cornelia Broady/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 8,2010 Landover Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral 8 DONALD R. CRAY 1661 Good Hope Rd SE Washingotn DC 20020 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1. En shock, or Immediate Cause (Final disease or condition resulting in death) Physician Atheroscheritic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner burial-trar and Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 donknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate ! 24100 1∏ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1.☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 🔲 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Injury Hospital or Attending 1- Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 17 Rev 1/2001

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

255 Rockville Pike, Rockville Maryland #125

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

31. Date filed (Month, Day,

2/100

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Beard 30, 2009 10:00 PM Betty Medical <u>Jane</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1031 St. Clair St. Hagerstown Washington 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** (Month, Day,) Days Min 1 - M 2 XF Months Hours Yrs Director 1927 215**-**26-1916 82 Tune Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral St. Clair 1031 Street 21742 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ George Α. Rankin Naomi Ε. Forrest e 1 and 2 should b of Health and Mer If item 27 is mark or other traumation 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawson / Daughter 1031 St. Clair St. Hagerstown Maryland 21742 Linda 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Haven Cemetery 1/4/2010 Hagerstown, Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave. Hagerstown, Maryland 23a. Part 1. Enter the disease, or complify one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying ence of בעב נט נטו מס מ נטווספ the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the atte should be detached for in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2× No 1 🗌 Yes Other: မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number,

within 24 hours after death.

To the Funeral Director: A completed 6

Hospital

State

Medical

29a. Certifier

29b. Signatu

(Check

Shahid

e and t

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Mahmood

580C

32. Registrar's Agnatur

Northern

City or Town, State)

29d. Date signed (Month. Dav. Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

rancis David E	Buck	Riease Type or Print in Black Indelible Ink State of Maryland / Department of F			ible.	
		1- For State Registrar Certificate of L			9. No. 2009	43189
Physic Medical Exam		Decedent's Name (First, Middle, Last)		Date of Deat Month	Day Year	3. Time of Death 1217 hrs
medicai Exam	mei	Francis David Buckler	City, Town, or Location of Death	December	27, 2009 4c. County of Death	1217 IIIS
		12562 Santa Rosa Road	usby		Calvert	
Funeral Director			If Under 1 Year If Under 24Hrs. Months Days Hours Min.		(MM/DD/YYYY) 9. Birth	n
Director		220-84-4057 1 X 2 F 47 Yrs. Usual Residence of Decedent	54,0	APITI	13,1902 Cou	intry) Maryland
any		10a. State 10b. County 10c. City, Town or Location	_			10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō	Maryland Calvert Lusby				1 Yes 2 X No
e Mary or 28a-	Director	10e. Street and Number	0f. Zip Code 20657	10	g. Citizen of What Coun	•
with the Maryland ns 23a or 28a-f sho be notified at once			ecedent of Hispanic Drigin? (Sp	ecify Yes or No-	United St	
death or item must b	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Puerto		White, etc.	
rs after ural",	by	3 Wildowed 4 Z Divorced if Yes, Give Year 1 Yes	es 2 X No specify: Usual Decupation (Give kind of w		Specify: Whit	
72 hou n "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retir		16b. Kind of Business/In	dustry
15-0036 filed within 72 hours at Hygiene. d other than "natural , the Medical Examin	Completed	Sheet N	Metal Mechanic		U.S. Cap	ital
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she ie event, the Medical Examiner must be notified at once	Be Co		18 Mother's Name Dorothy		*	
2121 hould be fi nd Mental is marked	To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	ddress (Street and Number or R			
ore, MD ; ss I and 2 shoo of Health and If item 27 is her traumation		Dora Carrick/Sister 26673 S 20a. Method of Disposition 20b. Place of Disposition	S Laurel Glen Ro			
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 Removal from State Crematory or other	aria a a s	nuary5,	20c. Location - City or T	own, State
altim nit. Pa artmer sortani		4 Jugonation 5 Other Specify:	e and Address of Facility Bri	2010	Waldorf, MI)
Per De linitial		MOO817 IP.A.	. PO Box 128.	Charlott	e Hall To MD	
Physician Medical	Ì	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.		respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) A Hypertensive Cardiovascular Disease Due to (or as a consequence of):				Death
	L	Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
nted d ansit		events resulting in death) Last Due to (or as a consequence of):				
e executed cian and rial - transi	dical	UNPENDED AMENDED				
760 ficate to g physi	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery	
Box 68760, death certificate be he attending physicid for use as the buri	sician/Med	past 12 months? 1 Live birth 2 Fetal c 4 Pregnant at time of death 5 Other	leath 3Ectopic pregnan (Specify)	су	Month Da	y Year
J. Bo the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the unde	duing agus alves in Deat I	220 Did tob		
P.O.	à	Morbid Obesity	mynng cause given in Part I.	1 ✓ Yes	acco use contribute to th	
rds, requir	etec			24a. Was an		psy findings available
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			autopsy perform 1 Yes 2	ed? death?	mpletion of cause of
tal Rectian: The	Bec	25. Was case referred to medical	26 Place of Death (Check or			
f Vil Physic er this	P	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury			esidence 6 Other; \$	Scene
On C ending ath. or: Aft	ţį	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	tod. Describe no	w injury occurred	
Division ospital or Attendin hours after death.	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fa	actory, office building, etc. 2	28f. Location (Str or Town, Sta	eet and Number or Rura	I Route Number, City
spi hou ner / fil		4 Homicide determined (Specify)			<u> </u>	
To the Ho within 24 To the Fu completely	Medical	one) (Check only one) (Check o	at the time, date and place, and c in my opinion, death occurred at	lue to the cause(the time, date an	s) and manner as stated d place, and due to the	cause(s)
7. × 7. 8	ğ.	and manner stated. 29b. Signature and title of certifier	29c. License number	1:	29d. Date signed (Month	n, Day, Year)
		M/hr Grand MD	O.C.M.E.		December 29, 200	9
		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	n Street, Baltimpre, MD 2	1201		
		31. Date filed (Month, Day, Year)	_			
Regist		JANO 4 2010 Senera B. park	- -			
DHMH 17 Rev 1/20	001	ÓRIGINAL				

DHMH 17 Rev 1/2001 DCME 2006

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State of Maryland / Department of Health and Mental Hygiene 1- For State State State Registrace MEND#2perMD, 12/29/09, BMW, MCO Certificate of Death Reg. No. 2009 43 9 (
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	RUCE	2. Date of De Month	PatDec. 27, 2009	3. Time of Death					
	Examir		4a. Facility Name (if not institution, give street and number) MONTGOMERY GENERAL HOSPIT	AC 4b. City, Town, or Location OLNEY, A		4c. County of Death)					
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 1 F 7. Age (In yrs. last 83	birthday) If Under 1 Year If Under 1 Year Months Days Hours	er 24 Hrs. 8. Date of Bin Min. (Month, Da April	8. Date of Birth (Month Day Year) April 10, 1925 Canada						
	/land f show ed at	호	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Location			10d. Inside City Limits					
	ne Mary or 28a-i notifie	Direc	Maryland Montgomery (Ol ney		10g. Citizen of What Cou	1 Yes 2 No					
	s 23a c	Funeral Director	3748 Carrisa Lane	20832		USA	intry?					
9036	within 72 hours after death with the Maryland glene. glene. then "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	ted by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever In U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexico 1 Yes 2 No Specify		14. Race - Amer Black, White Specify: Whit	, etc.					
21215-0036	within 72 hou giene. ner than "nat it, the Medica	Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) Secretary	ost of working	16b. Kind of Business I						
Maryland 2	ed v Hyg othe	To Be	17. Father's Name (First, Middle, Last) Frank Burgess Tanner	18. Mot	her's Name (First, Middle, label Black		inment					
			1	ber or Rural Route Number, Olney, MD	er, City or Town, State, Zip 20832	Code)						
Baltimore,			1 Division 2 K Communication 2 Disconnectification Control	ee of Disposition (Name of letery, crematory or other place) opolitan Cremator	Date Dec. 29,	20c. Location - City or T Alexandria,						
Balt	permit. Page Department of Important: If any injury or once.	10	21. Signiture of Funeral Service Licensee	22 Name and Address of Eaci Francis J. Co 500 Universit	l lins Funer	al Home Inc. Silver Spri	ng, MD 20901					
· i	Physician/ Medical		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									
	Examiner	er		STE NOSIS			SWEEK					
5	and transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence)	32 of).								
09/	te be e nysicial ne buri	dical	d.	33 01).								
. Box 687	uithin 24 hours after death, within 24 hours after death, To the Funeral Director. After this certificate has been signed by the attending ph completed filled in by the funeral director, page 2 should be detached for use as the	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 movths? 1	eath 3 Dectopic pregnancy		23d. Date of deliv	very Day Year					
s, P.0	ilres that t signed b Id be deta		Part II. Other significant conditions contributing to death but not resulting REWAL FALCURE		t I. 23e. Did to	obacco use contribute to t	he cause of death?					
Division of Vital Records, P.O.	sician: The law require certificate has been si rector, page 2 should I	PLEURAL EFFUSIONS 23e. Did tobacco use contribute to the cause of death of the cause of death? PLEURAL EFFUSIONS 24a. Was an autopsy performed? death? 1 Yes 2 No 3 Probably 4 U V V V V V V V V V										
/ital	sician: certific lirector,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Proceedings 2 Specified 1	Other:	ath (Check only one)							
n of \	Attending Physician: The is er death. ector. After this certificate he by the funeral director, page	27. Manner of Death 28a. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of injury 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 Natural 5 Pending 2 Accident Investigation 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of injury 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 Yes 2 No										
Jivisio	al or Attendates after deat Director:	Certificate:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)			Street and Number or Rura vn, State)	l Route Number,					
:	Io the Hospital or within 24 hours aft. To the Funeral Dir. Completed filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and coly one) 3 Certifying Nurse Fractionar to the basis of my knowledge.	d/or investigation, in my opinion, death of	occurred at the time, date a	ind place, and due to the ca	use(s) and manner stated					
	5		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print) WEE PHI	UPDR #3	OLNEY, M	0 20832					
	Stat Registra	e	31. Date filed (Month, Day, Year) 31. Registrar's Signature									

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 12 2009 Year **Physician** Kelvin Thomas Bell Sr. 15 1300 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PG Doctors Hospital Lanham 9. Birthplace (State or Foreign Country) Vash. DC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–02–1959 Social Security Numbe 7. Age (In yrs. last birthday) Funeral Days Min Hours 219-72-6446 1 🖾 M 2 🗆 F Wash. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1XYes 2∏No MD PG Clinton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 USA 10112 Quiet Brook Ln. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ferguson Enterprise Elementary/Secondary (0-12) 12 College (1-4or 5+) Warehouse Foreman Inc. permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygid Important: If item 27 is marked other in any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bell Smith Rev. Mack Μ. Gloria E. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10112 Ouiet Brook Ln. Clinton, MD 20735 Dierdre L. Bell/ Sister-in-law Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Heritage Memorial Pk | 12-23-2009 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitiRonald Taylor II FH 21. Signature of Funeral Service Licenses Cono 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that rused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Accident Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for sels consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 I Inknown á 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Coronary Artery Disease Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia has performed 1 □Yes 2 🛛 No 2 🛛 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 29c. License number D65909 Ene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Rd. Lanham, MD 20706 Fasil Alemu, M.D. 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State **DEC 3 0 2009**

DHMH 17 Rev 1/2001

Registrar

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eugenio Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

32. Registrar's Signature

www

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kathryn Ellen County 8:30 A M December 24, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 29431 Matthewstown Road Talbot Easton Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Min. 1 □ M 2 🗓 F Months Days Director 57 220-60-3970 07/10/1952 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f shov Examiner hast by notified at Director 1 XYes 2 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29431 Matthewstown Road 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
snt: If item 27 Is marked other than "natural", or ite 0 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 N Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+ Captain Boating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Waite P Regina W. Perkall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Feil/Daughter 29431 Matthewstown Road, Easton, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation | 12/28/2009 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. MERCERON YOHN K. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, ML shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Aggressive **Physician** 24 caus. Meningio Ma resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

State Registrar

Delean-Botkin, CKNY ٤. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifig

32. Registrar's Signature

lear Soth CKNP

8579 Commerce Drive, Ste. 106, Easton, MD

29c. License number

R126198

29d. Date signed (Month, Day, Year)

21601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** HENRY W. CLARK , Jr. DEC. 26. 2009 10:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT EASTON TALBOT HOSPICE HOUSE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** MAY 27, 1928 WASHINGTON, DC Director 578-48-6662 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be rothed at 1 ☐ Yes 2 X No Directo MARYLAND TALBOT OXFORD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5801 DEEP WATER DRIVE UNITED STATES Funeral 21654 permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ 12 any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) INFORMATION Elementary/Secondary (0-12) College (1-4or 5+) 5+ PRESIDENT 12 SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည BEATRICE SHAW HENRY W. CLARK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1145 AUGUST WOODS ANNAPOLIS, MD 21403 ALLEN C. CLARK III/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON, DC ROCK CREEK CEMETERY | DEC. 31, 2009 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN R. MERCEROR Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and use as the burial-transil Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of eause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 EGLSEDER, LUDWIG J. MD 503 CYNWOOD DR. EASTON, MD 21601 Year) Registrar's Signat State **DEC 29 2009**

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cer	tificate of L	Death	Reg. No. 2009 43195					
п	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	3. Time of Death			
	/Medic		Margaret Katharine Cook				Dec 24		0:00 A M			
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		4c. County					
-			3420 Walters Lane 5. Social Security Number 6. Sex 7. Age (In vrs. last	t histheless)	Fores	tville	Irs. 8. Date of Bir		e George's 9. Birthplace (State or Foreign			
	Funeral Director		S. Social Security Number 6. Sex 7. Age (In yrs. last 241 40 6444 1 M 2 K F 82 82 Usual Residence of Decedent	Yrs.	Months Days		lin. July 8	ay, Year)	North Carolina			
	land It		10a. State 10b. County 10c. City, To	own or Loc	cation				10d. Inside City Limits			
	Mary First	ģ	MD Prince George Fore	orestville					1 □ Yes 2√√No			
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V	What Country?			
	h with		3420 Walters Lane		20	747	United	United States				
	deat ms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V			' (Specify Yes or No uerto Rican, etc.)		ce - American Indian,			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fru Medical Examiner must be rediffied at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Midowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Yes 2 No	Specify:	erio nicari, etc.)		ck, White, etc. ^{y:} White			
5-0	72 ho	etec	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	lent's Usual Occupa	ation during most of s	workina	16b. Kind of Bu	usiness/Industry			
Maryland 21215-0036	within jiene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	nonaker)	g	Dome	estic			
b	il Hyg other rent,	Be C	17. Father's Name (First, Middle, Last)		Hemaker	18. Mother's N	Name (First, Middle					
<u>a</u>	ald be Aenta rked ric ev	To B	William M. Vick			ľ	Maggie :	Bell Dav	is			
ary	shou and N s mai	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or	Rural Route Numb	er, City or Town,	State, Zip Code)			
Σ,	and 2		Ginger Ramsey (Daughter)	3420) Walters	Lane,	Forestvi	11e , MD	20747			
ore	of He of Herr roth		20a. Method of Disposition 20b. Place	e of Dispos	sition (Name of natory or other place	e) !	Date	20c. Location -	City or Town, State			
altimore,	Page ant: I						/31/2009	Rocky M	fount, N.C.			
Balt	permit. Departi Importi any inj		21. Sign ture of Funeral Service Licensee 1000057				ee Funera Road, Cl:		Inc6633 01d ID 20735			
			23a. Part 1. Enter the disease, or complications that caused the death.						Approximate			
	Physician		shock, or heart fallure. List only one cause on each line. Immediate Cause (Final	+1	DI		1:000	Interval Between Onset and Death				
100	/Medical		disease or condition resulting in death) a. Chronic Due to (or as a consequence)		trulive	2 July	moncery	disea	£			
	Examiner											
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68760,	ertificate be executed Jing physician and e as the burial-transit	Medical	d									
9 ×	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE:									
Bo	res that the death cer signed by the attendir be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	eath 3 🗆	Ectopic pregnancy	/			ite of delivery onth Day Year			
o.	he de	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death	n 5∟	Other (specify)							
σ.	that t ed by detac	H.	Part II. Other significant conditions contributing to death but not resulting	ig in the un	derlying cause give	en in Part I.	23e. Did 1	obacco use cont	tribute to the cause of death?			
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<u>6</u>	ath. r: Aff	at:	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury		:? Yes 2 □ No						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death expensions after death and the second completely filled in by the funeral director, page 2 should be detached for us	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (City or To		per or Rural Route Number,			
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) (Check only one)	age, death and/or inv	estigation, in my o	ne, date and pl pinion, death o	lace, and due to the occurred at the time,	date and place,	anner as stated. and due to the cause(s)			
	o the	Me	29b. Signature and title of certifier		29c. License			29d. Date signe	d (Month, Day, Year)			
	->-0		> Hokalsin N	10	DO	052	1999	121	28/2009			
•	0 1		30. Name and address of person who completed cause of death (Item 23				- 4 4		00,00-1			
	DS6		Ali Rahimian, M.D. 10403 Hospit			e G-6,	Clinton,	MD 2073	5			
	Sta	te	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	-	The state of the s							

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylar		artment ortificate			Mental Hy	giene ()	09	4319	6
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			Washington Adv	entist Hos	pital	pital Takoma Park				Mont	gomer	У		
	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Months I		Under 24 Hr Hours Mir		th av. Year)	9. Birth Cou	place (State or F	oreign
ь	Director		212-49-7708	1□M 20XF	81	Yrs.	Worland	Jayo	10010	JUL 16	, 1928	Hai		
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	he M	Director	Maryland Mont	gomery	511	ver Sp	1				10g. Citizen	- ()A(h - 1 O - 1		~
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p	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Middle,	Last)				18	B. Mother's Na	ime (First, Middle	, Maiden Sum	ame)		
<u>a</u>	uld b Ments rrkad rtic e	To	Metellus			Ma	athieu	2	Zulema			Tue	lusmo	
Maryland 21215-0036	2 should and Men Is marka aumatic		19a. Informant's Name/Relations							lural Route Numb				
Σ	and 2 salth a n 27 Is		Carolle Cadet	/ Daughter		809	Heron 1	Drive	e, Sil	ver Spri	ng, Mar	yland	20901	USA
Baltimore,	- I = E		20a. Method of Disposition 1 🖫 Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S		20b. F A1w	Place of Disponentery, crematery, Crematery, Charactery May 121	sition (Name natory or othe ison nerair	r place)	JAN	Date 3, 2010	St. M	n City of T edard Hait	own State Archaie	ļ
alti	- E #		21. Signature of Funeral Service			1.000	T-2		1					
m	Depa Impo any in		21. Signature of Funeral Service ricensee M00956 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, Maryland 208											USA
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4	/Medical		resulting in death)		or as a conseq		INPARC.	LION						
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ó	an ar		resulting in death) Last	Due to (or as a conseq	juence of):								
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9	certificate be executed nding physician and use as the burial-transit	Physician/Medical	IF FEMALE:											
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<u>۳</u>	The ate h	Son								perfo	rmed? 2∭No	death?	2□ No	
ita	Physicien: The la rthis certificate has ral director, page 2	Be (25. Was case referred to medical examiner?					26	6. Place of De	ath (Check only				
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n	ng P		27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date o	f Injury n, Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe	how injury occ	curred		
<u>s</u> .	Attending r death. actor: After by the fune	catl	2 ☐ Accident investig	gation			М	1 🗌 Yes	2 □ No					
Division	I or Attending Ph after death. Diractor: After th I in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could of determined	lined 286. Place	of Injury - At he g, etc. (Specif	ome, farm, str	eet, factory, o	ffice		28f. Location (City or To		mber or Run	al Route Numbe	r,
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	To the Hospitel or Atteniwithin 24 hours after deatl To the Funerel Diractor:	edical	(Uneck only 2 Medical	ng Physician: To the Examiner: On the ba	sis of examina	wiedge, death	occurred at the occurred at th	the time, o	date and place on, death occ	e, and due to the urred at the time,	cause(s) and date and place	manner as s	stated. o the cause(s)	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifie	and mann	er stated.		200 1	icense nu	ımbor		20d Data sig	ned (Month	Day Voas	
		-	205. Signature and title of centre	Ople							29d. Date sig			9
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			30. Name and address of person	N/			-	ALES-	11.17	TAKOMA	Pani-	M A	MIAIM	
	Sta	te	TERRY JOD216 31. Date filed (Month, Day, Year)		rgistrar's Signa	00 CAG	KULL A	30 EN	ושטו	IVEROMA	THEK,	IV CINC	TLITUD	
	Registr		DEC 29 2		me &	ature for	Ked.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chavez Angelina Sophie Dect. 18, 2009 0029 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death
Montgomery Silver Spring Holy Cross Hospital Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 M 2 K 12/16/2009 none Director Marvland Usual Residence of Decedent id be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho or 28a-f show 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Montgomery Kensington 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA Funeral 20895 4019 Wexford Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 0 Specify: Guatemalan Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 X Yes 2 No White If Yes, Give 3 Divorced 4 Divorced Year or Dates Salvadora El permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none none 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jorge Alberto Chavez Lucila Chavez Guadron 19a. Informant's Name/Relationship (Type, Print) father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Jorge Alberto Chavez, 4019 Wexford Drive Kensington, Md 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Md 12/24/2009 PHIMIP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Respiratory arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Brain tumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à icate has been sig 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate I funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 😿 No 1 Yes 1 🔀 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury work? 1 Yes 2 No 5 Pending death. Accident Suicide within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

Leah Greenspan M.D.

Phulsc1 An

H64286

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leah Greenspan M.D. 1500 Forest Glen Dr. Silver Spring, Md 20910

29d. Date signed (Month, Day, Year)

12/18/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:02 al Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Park 1109 Talloma 1 gomes If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X** M 2 □ F Months Hours Min. (Month, Day, Year, Virginia Director -892 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Riverdale 1X Yes 2 ☐ No Princes Georges MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 United States 5902 48th Ave ritems 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian. Armed Forces 2 1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify.White 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/ADisabled 7th permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt one. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nannie Hoops Theodore Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5902 48th Ave Riverdale MD 20737 <u>Mary Carter Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 12/31/09 4 ☐ Donation 5 ☐ Other (Specify) Bladensburg, MD 22. Name and Address of Facility 106841 Southern W. Wesley Chavis III Funeral Service PA 54 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ throse disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death g ☐ Unknown as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy page certificate I 1 Yes 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury after death. 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Pranticipan To the best of my knowledge as all continued at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and a Certifying Number Pranticipan To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CR

Registrar
DHMH 17 Rev 7/2009

State

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Signa

AJE

Takoma Part MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600

32. Registrar

(PMM &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #2016 6 22 PET FH C900 12/08/2010 Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** arawas lames 844 AM 27 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett County Memorial Hospital Ganrett Oakland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Days Hours Months 1፟፟፟፟ M 2□ F Director 579-20-9968 85 10/20/24 Washington DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 US 706 E. Alder St. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Affiled 1 Grees.
1 ☑ Yes 2 □ No
If Yes, Give
Year or Dates: 1943–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than Auto Mechanic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Caraway Marie Empey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau Stephen Caraway / Son 5103 Irving St., St. Leonard Maryland 20685 20b. Place of Disposition (Name of Mary Land Vet. Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 2/02 \$2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Brentwood, MD. 22. Name and Address of Facility

George P. Kalas F.H.

3401 Bladensburg Rd. 1n Funexal Home Oxen HillRd. Oxen Hill wood, MB. 20722 MD 21. Signature of Funeral Sans Approximation of the constraint of the constrain Trances 23a. Part 1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart folium. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** ucar3 Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 : autopsy performed 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 1 Natural 2 □ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely 426154 address of person who completed cause of death (Item 23a) (Type, Print) iller D.O. 69 Wolf Acres Dr Oakland, MD 21550 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dozier Fulton larion Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kounty Washington Washington HOSpita ~wow~ lagers Social Security Number If Under Wear If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. April 24, ¥.1<u>934</u> Maryland Director 214-30-1907 75 Usual Residence of Decedent 1 and 2 should be filed within 72 hours area במבינה של fleath and Mental Hygiene. 23 or 28a-f show it flem 27 is marked other than "natural", or items 23a or 28a-f show it flem 27 is marked other than "dadical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland|Washington County Hagerstown 1 🗆 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 14639 Marsh Pike 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 💢 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adna John Fulton Irene Brewer Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14639 Marsh Pike Hagerstown, MD 21742 Ed Dozier-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If its any injury or ot Page 1 1 🗌 Burial 2 🖾 Cremation 3 🗀 Removal from State Smithsburg Crematory 1-1-2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 101 05 Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consuguence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown g Unknown Records, P.O. sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Nonpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dili this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 0068 976 December 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

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evene

Degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2009 Pascual Miguel Diaz Dec.28 2:57p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ F Months Davs Hours Mar. 10 none → Director 38 Guatemala Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d, Inside City Limits Director Prince George's Hyattsville MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8133 15th Avenue #201 20783 Guatemala "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Guatemalan the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
_life. DO_NOT use retired) 15 Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Landscape Work Landscape Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francisco Pascual Eulalia Pastora Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8133 15th Avenue #201 Hyattsville, Md20783 Mauro Pascual Diaz/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Cemeter crematory or other place) Servilletas 1 X Burial 2 Cremation 3 X Removal from State LLano Grande Ipala, 4 Donation 5 Other (Specify 1/06/2010 Guatemala uneral Service Lic PHTETP DE RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, Multiorgan failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Septic shock Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Bowel ischemic use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Febrile neutropenia Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Other (specify) Month Day Pregnant at time of death the detached 9 Unknown a Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer should be d acute promyelocytic leukemia 1 Yes 2 No 3 Probably 4 No Unknown chemotherapy, pancytopenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2X No Jas certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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State

Registrar

The

29b. Signature and title of certifie

M.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

Dec.28,2009

29c. License number

D0064100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DECEMBER 25 2009 8:10 A <u>LENA D. DICKERSON</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON 2 DOVER BROOK If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F 96 Director 183-12-1590 11/01/1913 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1X Yes 2 No rust be notified Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 2 DOVER BROOK 23a 21601 USA Funeral items. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. traumatic event, the Medical Examiner. Armed Forces? 1 ☐ Yes 2 📉 No Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 9 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify 2 Specify: WHITE 3 ▼ Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GUISEPPE MOFFA MARY JAPALUCCI ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 is any injury or other trau WILLIAM J. DICKERSON/SON 50 LONDONDERRY DRIVE, EASTON, MD 21601 Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 01/05/2010 | EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD nter the mode of dying, such as cardiac or respiratory artest. 23a Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rais ovoriany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) lesterolemic ews The law requires that the death certificate be executed percho attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a d be detached f o 1 ☐ Yes 2 M No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

4 State Registrar

31. Date filed (Monti

A

29b. Signature and title of certifier

Kussell

555 Cynwerd & Easton in & 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schille, Dd

29c. License number 447587

29d. Date signed (Month, Day, Year)

12-28-2009

			1 - For Stata Ragistrar	State of I	Maryland / Dep Ce	ertificate of			iene 009	43203	
	• .		Decedent's Name (First, Middle, Last	it)				2. Date of Death		3. Time of Death	
	Physici /Medic		Angela Santa Di	cola				December	r 25, 2009	1:16 p M	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat	h	4c. County of Death		
			Apex Health of			Silver			Montgomery		
	Funeral Director		5. Social Security Number 6. S 17 2-16-6591	9x □M 2⊠F	Age (In yrs. last birthda) 89 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, July 21	9. Birtl 1920 It	hplace (State or Foreign untry) a 1 y	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits	
	aho	ក	,	Tanaa aa al		lumbia				1 ☐ Yes 2 🛛 No	
	the N	Director	Maryland I 10e. Street and Number	Howard	CO	10f. Zip Code		10	og. Citizen of What Co	untry?	
	3a or		6365 Gray Sea Wa	v		210	45		USA		
	death ms 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S. 13	. Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame		
36	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23e or 28e-f ahow in Medical Experience must be motified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	⊡ No	1 ☐ Yes 2 No		o nican, etc.)	Black, White Specify:	White	
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed			edent's Usual Occup			16b. Kind of Business/	Industry	
215	thin 7 e. an "n Med	Completed	(Specify only highest gra	de completed) College (1-40	ilfe.	e kind of work done DO NOT use retire	d) auring most or wo	rking			
2	ed wil	Con		4	1	eacher			Educatio	n	
nd	be fill d off even	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M			
کار	d Mer narke natic	ပ္	Stefano Putignano 19a. Informant's Name/Relationship		10h Ma	line Address (Ctroot		Maria Vice	City or Town, State, 2	Zin Codol	
M	nd 2 saith and 2 saith and 2 saith and 27 is r		Susan L. Dicola/			5 Gray Se				ip code)	
ltimore,	ages 1 a nt of Hea :: If item ' or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑	Removal from Sta	ie I	ematory`or other pla	ce) Dec	. 31,	20c. Location - City or Vandergrif		
The part of the pa											
ш	20 E 8 3		23a. Part1. Enter the disease, or com	St							
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	sed the death. Do not en a line.	of foo	ng, such as cardia L	173		Approximate Interval Between Onset and Death Unknown	
	/Medical Examiner		resulting in death)	Due to (or	as a consequence f);		1	1	v po Dr	16	
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of):			m.X	V = 1		
6	ecuted and trans	caml	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of):	<u> </u>	~1	18600		3:	
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O. Box	ne death cer the attendir hed for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3 t at time of death 5	☐Ectopic pregnanc☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year	
۵.	res that the igned by be detact	y Ph	Part II. Other significant conditions of	ontributing to deat	h but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
rds	w requires been sign should be		Althemers	disec	75e			1	s 2□No 3□Pr	obably 4 Unknown	
Division of Vital Records,	e law re has be- je 2 sho	ompleted	Herpes	encep	halitis	9		24a. Was ar autopsy perform	v prior to	itopsy findings available completion of cause of	
<u> </u>	icien: The certificate rector, pag	O	HY pert	ension				1 Yes 2	1 ☐ Yes	2□ No	
Ž	sicien certif rector	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only one			
o	Phys r this ral dii	1: To	1 Ves 2 No 27. Manner of Death	28a. Date of I	njury 28b. Time	of 28c, Inju	ry at	28d. Describe ho	nce 6 ☐ Other (Special of the control of the contr	city)	
o	Attending Physicien: If death. ector: After this certification in the funeral director, I	tlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month,	Day Year) Injury	Wo	rk? Yes 2 No	choked	d on foo	d	
<u> S </u>	or Attendin after death. Director: Af in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28a Place of	Injury - At home, farm, setc. (Specify)	street, factory, office		28f. Location (Str	reet and Number or Ru	Parker ST	
	tel or s afte al Dir ed in	Cert		Nurs	ing Hom	e-Apex	Health	Silv	er spring	MP 20910	
	To the Hospitel or Attending Physicien: The la within 24 bours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Exan	niner: On the basis	est of my knowledge, de s of examination and/or	ath occurred at the ti	me, date and place	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
	within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner		29c. Licens			9d. Date signed (Mont		
	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			sdy		1	43121		12/26/0		
(3				of death (Item 23a) /Tuo				, ,		
	_		30. Name and address of person who NURUL CHUWD 31. Date filed (Month, Day, Year)	HURYIN	10; 15216	DINO DI	RIVEIB	BURTONS	VILLE,	MD 20866	
	Sta	te	31. Date filed (Month, Day, Year) DEC 29 2	32. Flegi	strar's Signature						
*	Registr	ar	UEC 29 2	JU9 CAN	strar's Signature	acke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 27, 2009 Dec. 5:20 PM Eunice Yancey DeMyers 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death P.G. Fort Washington 12007 Fort Washington Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🔀 F 70 10 - 8 - 39Louisa Cty, 225-52-1579 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County P.G. Fort Washington 1 XYes 2 □ No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12007 Fort Washington Road U.S.A. 20744 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education $5 \pm$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Payton Yancey Nellie Hooker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12007 Ft. Wash. Rd. Fort Wash. Md. 20744 Don DeMyers/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/7/10 4 ☐ Donation 5 ☐ Other (Specify) Yancey Family Cem Louisa, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. In ultu HICKUN 22 814- Upshur Street, N.W. D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Department of Health ar Important: If item 27 is any injury or other trauonce.

Physician

/Medical

Examiner

Funeral

Director

show

with the

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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d other than "natural", or items 23a or 28a-f sho event, the Medical Evander must be notified at

and burial-trar attending physician the jo the detached þ page 2 should peen has certificate

certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Examine Physician/Medical þ Completed

Medical

Hospital or Attending Physician: 24 hours after death. Be ဥ this After Certification:

the Funeral D rector: A the the within To the Registrar

State

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

110061

29d. Date signed (Month, Day, Year)

ress of lerson w completed cause of death (Item 23a) (Type, Print)

Madhu Mohan 6502 Keni lworth Ave. guite 100 Riverdale, MD 20737 31. Date filed (Month, Day,

DEC 3 0 2009

29b. Signature and tipe of certifier

30. Name and

a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Harvey Joseph Dant, Jr. Medical December 2009 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial Talbot Hospital Ea stor If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yea 11v 31, 1 1 ፟ M 2 □ F Washington, 577-46-9085 Director 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Talbot Maryland Easton 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8669 Brenton Drive 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", res, Give Year or Dates. 1955–1957 Specify: 3 Divorced 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic mand. Elementary/Seconday (0-12) College (1-4 or 5+) Harvey Plumber Plumbing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Joseph Dant, Sr. Margaret Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Dant / Wife 8669 Brenton Drive, Easton, MD 21601 Dant 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/2/2010 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). ii any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 0 No Certificate: To 1.☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral D the Hospital Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 12/28/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fernandez Month 12 Pierceson 2009 12:44 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern MD Hospital Clinton PG Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02–18–1945 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 XM 2 X F Months Country)
Wash 577-56-1063 **Director** 64 DC Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** Clinton MD PG 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9413 Surratts Manor Dr. 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 106 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Types 2 No 1964-Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: Black Specify: 3 Widowed 4 Divorced 1966 Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Williams Edward Fernandez Alberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2633 Jasper St. SE #1 Wash. DC 20020 Precious Fernandez/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 1-6-10 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service License 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ulmonory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner heralo sellor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Ø No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work' 1 Yes 2 🗆 No Director: A 2 Accident
3 Suicide Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical

State Registrar

3t

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

069983

- 7503 Surratts Road, Clinton, Maryland 20735

29d. Date signed (Month. Dav. Year)

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DHMH 17 Rev 1/2001

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1250 M Dec 25,2009 Joseph John Gallagher /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Salisburg Rehablitation of Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Wicomico Salish 8. Date of Birth (Month, Day, Year) (State or Foreign 7. Age (*In yrs. last* 75 **Funeral** Days Months Hours 1 💢 M 2 🗆 F 10/27/1934 110-26-7568 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State show ? is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2√ No Director Ocean Pines Worcester 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 16 Wood Duck Dr. 21811 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white 6 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) General Electric Engineer Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event, II <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Cornelius Gallagher Ann Nolan ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 Wood Duck Dr., Ocean Pines, MD 21811 Grace R. Gallagher / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of F 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/28/2009 Frankford, DE 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 21. Signatur of Funeral Service I 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Can 10 ear Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the as If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? /es 2 \(\int\) No Hospital or Attending Physician: The certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **₽**∤¶0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) amount of the cause of the caus 2 ☐ Medical Examiner: 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin. ET 10+1 William H-

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2009

		1	State of Maryland / E	Department of Health and N Certificate of Death	Mental Hygiene Reg. No	2009	43209
	Physici		1. Decedent's Name (First, Middle, Last) AMV Crarrett		2. Date of Death Month Da	200g	3. Time of Death
-	/Medic Examin		4a. Facility Name (If not institution, give street and number) Manor Care Towson	4b. City, Town, or Location of Death		: County of Death	iore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bin		8. Date of Birth (Month, Day, Year)	Q Pirtholo	ace (State or Foreign
	uryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Towr	nor Location Baltimore	/		d. Inside City Limits
	ith the Ma or 28a-f s	Directo	Maryland North	10f. Zip Code		itizen of What Countr	1 ☑Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanithat rotal te metified at once.	Funeral Director	1633 E., 25 Hb. St. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America Black, White, et	
9000	hours afte ural", or it	d by F	1 Never Married 2 Married 1 Yes 2 M6 If Yes, Give Year or Dates:	1 □Yes 2 □10 Specify:		Specify: Bla	ick
21215-0036	within 72 ene. than "nat ne Medic	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Homemaker	ing 16b. K	Kind of Business/Indu	ustry
	d be filed ental Hygi ced other c event, L	Be	17. Father's Name (First, Middle, Last) Thomas Braixton		e (First, Middle, Maider	1 Surname)	
Mary	id 2 shoul Ith and Mi 27 is marl traumati	To		. Mailing Address (Street and Number or Ruy		or Town, State, Zip	Code)
Baltimore, Maryland	ages 1 ar ent of Hea nt: If item 3 y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ry, crematory or other place)	4 4	ocation - City or Tow	
Baltir	permit. P Departme Importan any injur		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility 7	Ker Funer	al Home to	A. 21229
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
and the same of	Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence)		onik		
	uted d insit	Examiner	Sequentially list conditions, it is a least cause. Enter Underlying Cause, (Disease or injury)		VPV/~		
68760,	ficate be executed physician and s the burial-transit	cal Exa	that initiated events 'resulting in death) Last C. Due to (or as a consequence of	of):	_		
Box 68	leath certificat attending phy i for use as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	y
P.O. B	t the death by the atte ached for	Physician/M	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month [Day Year
rds, F	Hospital or Attending Physician; The law requires that the death certif 24 hours after death. 24 hours after death. 24 hours after death. 34 hours after death settlifficate has been signed by the attending itely filled in by the funeral director, page 2 should be detached for use at	Š	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the	
Records,	he law requir te has been s age 2 should	Completed			24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
Vita	sician; T certifica irector, pa	Be	25. Was case referred to medical examiner? 1 Yes 2 Ivo Hospital: 1 Inpatient 2 FR/Out	_ Other:	1 □Yes 2 □M h (Check onfy one)		2 ₩ No
Division of Vital	ding Physician; The lav h. After this certificate has funeral director, page 2	tion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	tipatient 3 DOA Nursing Ho Firme of njury at Work? M 1 Yes 2 No	ome 5 ☐ Residence 28d. Describe how inju)
Divisi	I or Atten after deat Director: I in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fai building, etc. (Specify)		28f. Location (Street a City or Town, State	nd Number or Rural e)	Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral but th	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	, and due to the cause(rred at the time, date ar	s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, D	Jay, Year)
			30. Name and address of person who completed cause of death (Item 23a)	Mam/Noods Ru	nd. M	0 812	34.
	Sta Registra		31. Date filed (Month, Day, Year) JAN 14 2010	hard	<u> </u>		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 25. Physician/ 8:35p M 2009 Adele Gannett Maru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Rockville Nursing Home Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Pay, Yea June 12, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year Funeral 1 □ M 2 🕱 F Days **Director** 578-01-7189 93 June Italu Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14510 Homecrest Road, Apt. #2021 20906 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene, item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Woodward & Lothrop Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Louise Fieni Bernardo Piccioni 19a. Informant's Name/Relationship (Type, Print) 20906 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14510 Homecrest Rd., Apt. #2021, Silver Spring, MD Page 1 and 2 Diana L. Gannett - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a
Department of 8 Important: If it any injury or o 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 01/06/2010 Brentwood, Maryland 21. Sign ture of Funeral Service Lice see 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter title disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Hypertensive Heart Disease Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Disection of Aorta the burial-tran attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Dementia Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a, Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month. Dav. Year) women D0047330 December 26, 2009

Registrar
DHMH 17 Rev 7/2009

State

Thomas

31. Date filed (Month, Day, Year)

Joseph.

DEC 29 2009

Edmonston Dr.,

Suite 207, Rockville, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50 W.

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ REEN Year O'A 1934 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 9516 51st avenue College Prince Payk GROY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Month Day, Year 5 58 Director Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director College Yes 2 No 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Private Maintenance injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Green Ida Mal Wasning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9516 515t ave College, Park. 20b. Place of Disposition (Name of cemetery, crematory or other) 20a, Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 02 Landover, 12010 Harmon UMPMoria I ParK! 4 Donation 5 Other (Specify) 21. Signature of Funer Service Licensee 814 Uponur St NW Wasn., DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heartifallure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No To Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie completed ause of death (Item 23a) (Type, Print)

State Registrar

45

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ORMAR)ecembe 300 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPAD Hagerstown Bunta aton Va ashin If Under 1 Year If Under 24 Hrs. Birthplace State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Yea Director 217-42-0795 63 1946 Marvland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington HAgerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 229 Merbaugh Dr. 21740 U.S.A Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 - Widowed 4 - Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 10 Manager Storage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Kenneth Vernon Mallick Helen Gingell Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hall George Jr. Husband Merrbaugh Dr. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 1/2/2010 Maryland Signature of Funeral Sedice License 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave. Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) tracrania Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural 1 Tes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier December 31 2009

Registrar

State

31. Date filed (Month,

JAN 05

ton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G899, 1/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 **JAMES** HAYNES DECEMBER 7:35 Α Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL FOREST HILL HEALTH & REHABILITATION HARFORD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Yea 09-01-191 1 X M 2 □ F Days Min Hours 92 Yrs Director 218-03-7454 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Forest Hill 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must he Funeral 1723 Boggs Rd 21050 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James H.E. Haynes Marie Wiedenhan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Haynes (Son) 1723 Boggs Rd Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem. 01-06-2010 Owongs Mills, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 - tages Physician/ en disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No ed by the a Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably √ 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No hours after death.

neral Director: After this certificate I
d filled in by the funeral director, page 1 Yes 2 No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Nesidence 6 Cther (Specify) 1 🗌 Yes 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No ☐ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Day 5 032235 December 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

DAVID DUNN

32. Regist ar's Sign

615 W. MACPHAIL ROAD - BEL AIR, MD 21014

			1 - State Registrar	ŕ	Ce	rtificate o	f Death	R	eg. N2 0	09	4321
	Physic	ian	1. Decedent's Name (First, Middle, La	•				2. Date of Dear Month		Year Loc 9	3. Time of Death
	/Medi		Elizabeth Hume			T					
F	Exami	ner	4a. Facility Name (If not institution, giv Roland Park Place			4b. City, Town Balti	n, or Location of Deat more	h	4c. Count	y of Death	
-8.00	Funeral		Social Security Number 6. S	0 , ,		If Under 1 Yes		8. Date of Birth	Year)	Cou	place (State or Fore
	Director		016-26-5254	□M 2 K F 98	Yrs.	INIONITIO Bay	, o Hodro Island	01/19/1	911	Virg	ginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Lo	noation					10d. Inside City Limi
	aryia shov d at	_	10a. State 10b. County	10c. Cit	y, rown or E	callori					1 ZYes 2 ☐ I
	8a-f	Director	MD	Ba	1timor						
	vith the	Dir	10e. Street and Number			10f. Zip Ccd		1	0g. Citizen of		•
	ath v s 23a nust	Funeral	133 Fireside Cir			2121			Unite		
	er de Items	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.5. 13.	Was Decedent of If Yes, specify C	of His <mark>pani</mark> c Origin? (S Juban, Mexican, Puer	specify Yes of No- to Rican, etc.)		ce - Amen ick, White	ican Indian, , etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1□Yes 2□ x	lo Specify:		Speci	fy: Whi	te
윽	tura tura	ed	15. Decedent's Ed		16a. Dece	dent's Usual Oct	cupation		16b. Kind of E	Business/Ir	ndustry
15	in 72 in 72 fedic	olet	(Specify only highest gra	de completed)	(Give	kind of work do DO NOT use ret	ne during most of wo ired)	rking			,
12	with lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Hom	emaker			Own H	ome	
D	filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Last,	1			18. Mother's Na	me (First, Middle, i	Maiden Surna	me)	
an	lid be lenta ked ic ev	To B	Alan Hume				Elise G	ardner			
äZ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)	et and Number or R	or Rural Route Number, City or Town, State, Zip Code)					
Š			Elise Ryan / Daug	hter	e Circle Baltimore, MD 21			1212			
Baltimore, Maryland 21215-0036	s 1 a of Hea item othe		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other p	nlace)	Date	20c. Location	- City or T	own, State
	Pages Tent of H		1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	memoval from State		Cemeter		30/09 A	lexand	ria,	VA
	permit. Departm Importa any inju		21. Signature of Funeral Service Lice				dress of Facility ${f J}_{f O}$		er's S	ons	nc.
ä	lmp any any		William (10	Bungar	5	130 Wis	consin Av	e. NW Was	hingto	n, Do	20016
Н	.7 0		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not en	ter the mode of	dying, such as cardia	c or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final	advanced w							Onset and Death
J	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		- Color	2 40 401	- William	- may	che.	1 cars
	Examiner										
, I	1000	ē	Sequentially list conditions, if any, leading to minimidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
D	od d	Ē,									
ó	exectan an an rial-tr	EX	resulting in death) Last	Due to (or as a conseq	uence of):						
68760,	te be ysicia e bu	ca		_ d							
9	ertificate be executed ing physician and as the burial-transit	Medical				· · · · · · · · · · · · · · · · · · ·			1		
ŏ	eath cel attendir for use		iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregna	incv			ate of defin	
. B	dea ed fo	sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of o		Other (specify,			N	lonth	Day Year
P.0	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/	9 □ Unknown								
	es th gned oe de	by F	Part II. Other significant conditions	ontributing to death but not res	ulting in the u	inderlying cause	given in Part I.				the cause of death?
ord	w requires been si should b	pa						1 🗆 Y	es 2 No	3 ☐ Pro	bably 4 □Unkno
e C	law as b	Completed						24a. Was a	an 24b	. Were aut	topsy findings availa ompletion of cause o
T.	ate Th	E O						perfor 1□ Yes	med?	death? 1 ☐ Yes	
ita	siclan: The certificate h rector, page	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or	ne)		
>	Physic this ce al dire	일	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□DOA	Other: 4 Nursing	Home 5 ☐ Resid	ence 6 🗆 O	ther (Spec	ify)
0	Attending Physician: r death. ector: After this certific: by the funeral director,	Ë	27. Many r of Death 1 ∡Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Ir	njury at Vork?	28d. Describe h	ow injury occu	rred	
<u>Si</u>	Attendi death. ctor: A y the fu	atic	2 ☐ Accident investigation				☐ Yes 2 ☐ No				
Division or Vital Records,	l or Attenafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury · At he building, etc. (Specif	ome, farm, st fy)	reet, factory, office	ce	28f. Location (S City or Tow	treet and Num n, State)	ber or Ru	ral Route Number,
	lospital or Att thours after de uneral Direct ely filled in by t										
	Hospital 4 hours a Funeral tely filled		(Check only 2 Medical Exal	ysician: To the best of my kno niner: On the basis of examina							
	o the Hosi ithin 24 ho o the Fund ompletely f	Medical	one) 29b. Signature and title of certifier	and manner stated.			ense number				
	0 = 0 0	-	ZDD. DIGHTALLINE AND TILLE OF CETTIFIE!			250, LICE	SHOC HUHHUEL		29d. Date sign	eu minoritr	, way, itali

In Tabelle Tac megh 70 013657

29d. Date signed (Month, Day, Year) December 21, 2009

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

43214

4:500 M

9. Birthplace (State or Foreign

10d. Inside City Limits 1 XYes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TESPSELLE The GREGIR, 830 W 40 th Street Baltinitie, Ma 21211

State Registrar

DEC 3 0 2009

31. Date filed (Month, Day, Year)



		-	For State	State of Maryland	•	irtment of F tificate of L				09 4	3215
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Deat	th	<u> </u>	ime of Death
Př	nysicia		Reginald Durwin	Hunt				Month Decembe	er 31, 2	Year	:06 a M
. Е	Medic xamin		4a. Facility Name (if not institution, give s			4b. City, Town, o	r Location of Death		4c. County of Death		
			23745 Hollywood	Road		Leona	rdtown		St.	Mary's	
	ıneral		5. Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthplace (S Country)	State or Foreign
Dir	ector	ŀ	219-52-5700 Usual Residence of Decedent	58	Yrs.			04/20/1	951	<u>Marylano</u>	d
PL	at	5	10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Ins	side City Limits
lanyla	3a-f s tified	Director	Maryland St. Mary'	s Leon	ardtow	n				1 [☐ Yes 2 🛣 No
the N	or 2		10e. Street and Number			10f. Zip Code	_		10g. Citizen of V	Vhat Country?	
with	s 23a ust b	Funeral	23745 Hollywood F	Road		20650		τ	Jnited S	States_	
death	item ner m	2	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H	lispanic Origin? (Spa an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indi ck, White, etc.	ian,
36 after	l", or kamir	p	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔼 No If Yes, Give		☐ Yes 2 XNo			Specify:		
21215-0036 within 72 hours after rgiene.	atura cal E	Completed	15. Decedent's Ed	Year or Dates.	16a Deced	ent's Usual Occup	pation		16h Kind of Bu	Black_ usiness Industry	
715 h	an "n Medi	E I	(Specify only highest gra-		(Give k	ind of work done of NOT use retired)	during most of work	ing	TOD. KING OF BO	asiness moderly	
212 withir giene	the th		12	College (1-4 of 5+)	Dieti	cian Ass	istant		Senior	Care	
filed al Hys	d oth		17. Father's Name (First, Middle, Last)	-			18. Mother's Nam	e (First, Middle, N	Aaiden Surname	?)	
Maryland 2 should be filed th and Mental Hy	atic e	욘	William I. Hunt				Vera E.	Ross			
Mar shou	7 is m raum		19a. Informant's Name/Relationship (Ty	pe, Print)	1		and Number or Run				
e, Pand 2 Health	em 2 ther t		Bertha M. Hunt/Wif			Hollywo	od Road,			D 20650 - City or Town, St	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	er of		1 ☐ Burial 2 🛛 Cremation 3 ☐	Removal from State	emetery, crem	natory or other plac	ce)				
tin. Pa	ortani injury		4 ☐ Donation 5 ☐ Other (Specify	Bri			Cre 01/11				
Ba pern Depi	Impor any in once.	9 J	TAMENTAL	field, Jr. MOO	0052 22	2955 Holl	ess of Facility Bri Lywood Roa	nsileid ad. Leon	runera. ardtown	Home,	P.A. 0650
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										oximate
Phys	ician		Immediate Cause (Final	le cause on each line.	00	1001					val Between et and Death
Me	edical		disease or condition resulting in death)	a. Due to (or as a c vise u	ence of):	rue					
Exa	miner	L	Sequentially list conditions,	h							
-	±	Examiner	if any, leading to immediate	Due to (or as a consequ	ence of):						
scuted .	and trans	xan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequ	sence of:						
oe ex	attending physician and for use as the burial-transit		resulting in death) Last								
760	phys the l	edical		d							
	nding Ise at	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		1			23d. Da	te of delivery	
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific rs after death.	d for 1	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta		Ectopic pregnan Other (specify) _	cy		Мо	onth Day	Year
thed .	by the tacher	hys	g 🗌 Unknown	9 L Unknown							
S that	been signed by the should be detached	by	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause gi	iven in Part I.			ribute to the caus	
ds,	ould t	ted						1 💢		3 Probably	
CO law re	as be	Completed			***			24a. Was a autops	sy	Were autopsy fin- prior to completion death?	
8	cate h							perfor 1 Yes	2 No	1 Yes 2 1	No
ician	s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:		_ Oth	lace of Death (Chec				
Phys .	r this ral dii	<u>ان</u>	27. Manner of Death	1 Inpatient 2 I	ER/Outpatier 28b. Time of	It 3 🗆 DUA	4 L Nursing H	ome 5 X Reside			
on of a	; Afte	cate	1 Natural 5 ☐ Pending 2 AccidentInvestigation	(Month, Day, Year)	injury	wor	k?] Yes 2 □ No				
Sicolar Atter	Director: After this d in by the funeral di	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e, Place of Injury - At ho	me, farm, stre	eet, factory, office				er or Rural Route	Number,
Div tal or rs afte	al Dir			building, etc. (Specify				City or Towr			10
lospi 4 hou	uner ed fill	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ician: To the best of my knowled ner: On the basis of examination	edge, death on and/or invest	occured at the time	e, date and place, a ion, death occurred a	nd due to the cau at the time, date ar	ise(s) and manning place, and due	er as stated. e to the cause(s) ?	and manner stated.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Dire completed filled in b	Me		e Practioner: To the best of my			ne time, date and pla	ce, and due to the	cause(s) and ma		
P 5 ≱	6 8		2.55. Oignature and the orientiner	M			00557		Lou, Date signer	a invioliti, Day, Ye	our)
			30. Name and address person who c	ompleted cause of doath (Hom	23a) (Tvpe 5		00271	<u> </u>	1 7	10	
reli			Jennifer Schmid				Lane, Leo	nardtow	n, MD 2	0650	
	Sta	te	31. Date filed (Month, Day, Year)	32 Kegistrar's Signal	ture .		,				
E	Registr	ar	JAN 0 6 20	110 Leura	A. Asi	ELKE					

DHMH 17 Rev 7/2009

		1 - For Stata Registrar	State of M	laryland / D	epartment Certificate			ind Me		giené Reg. No		43216	
		Decedent's Name (First, Middle, La	st)					2	2. Date of Dea	ath Day	y Year	3. Time of Death	
Physici /Medio		Thelma W. Houck				Dec. 23,				,	2009	8:55 A M	
Examir		4a. Fecility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					4c. County of Death		
		Charles County Nursing & Rehab				IaPlata If Under 1 Year If Under 24 Hrs. 8, Date of Birth					Charles		
Funeral Director		377 20 3000	ex 7. A	ge (In yrs. last birti 89	rs. Months	Days	Hours	Min.	B. Date of Birt (Month, Da Sust 19			nplace (State or Foreign untry) irginia	
pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits	
Maryli f eho	ō	MD Charles		La I	Plata							1 ☐ Yes 2 X No	
the the 28a-	Funeral Director	10e. Street and Number				10f. Zip Code 10g				10g. Cit	izen of What Co	untry?	
3a or	0	6250 Ripley Road				20646					USA		
deati	ner	11. Marital Status	t Ever in U.S.	U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl			gin? (Spec	ify Yes or No		14. Race - Ame Black, White			
after or its		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 □ Divorced Year or Dates:				1 ☐ Yes 2 ☐ XNo Specify:					Specify: White		
urai',	d by	3X Widowed 4 □ Divorced							6b. Kind of Business/Industry				
in 72	Completed	(Specify only highest grade completed) (Gi				edent's Usual Occupation 1 b kind of work done during most of working DO NOT use retired)				100. K	ob. Kind of business/industry		
y with	E O	Elementary/Secondary (0-12) College (1-4or 5+) 2 Secretary							US Navy			7	
of Hys	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle,	Maiden			
Menta Menta	To E	Walter Lee Ward				P	Arlin	e Dor	naldsor	1			
2 sho and ie my		19a. Informant's Name/Relationship (Турө, Print)	19b.	Mailing Address	(Street ar	nd Numbe	r or Rural .	Route Numbe	er, City o	or Town, State, Z	ip Code)	
r and leelth		Arlene Conover/D 20a. Method of Disposition	aughter		254 Rip1		oad,	La Pl			0646 ocation - City or	Town State	
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		1 ABurial 2 ☐ Cremation 3 ☐		cemeter	y, crematory or or	ther place,							
portition of a many profiled at 12.10.0000 permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show supplicity or other treumstite event, the Medical Exeminar must be notified at once.		4 □Donation 5 □Other (Special 21. Signature of Funeral Service Lices		00945	y Memor							yıand	
Depermine only in		Marin C.	Ehol)	AREHA							46	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
Physician		Immediate Cause (Final disease or condition resulting in death) a. Cerebral atherosclerosis									Onset and Death		
/Medical Examiner		resulting in death)	Due to (or a	s a consequence o									
	<u></u>	Sequentially list conditions,	b. Due to (or a	s a consequence o	of)·								
uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	.,.										
exection ending	Exa	that initiated events resulting in death) Last	of):										
Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien end rail director, page 2 should be delached for use as the burial-transit	cal	g d											
ing pr	Med	IF FEMALE:	23c. If yes, outcom		·· · · · · · ·								
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		3 ⊟Ectopic pregnancy					23d. Date of delivery Month Day Year				
w requires that the death certificate been signed by the ettending phenould be detached for use as it	Physician/Med	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown											
that i		Part II. Other significant conditions	contributing to death	but not resulting in	the underlying ca	ause giver	n in Part I.		23e. Did t	obacco	use contribute to	the cause of death?	
quire n sign	ed by	1 Yes								Yes 2	2 No 3 Probably 4 □Unknown		
aw re	Completed								24a. Was		24b. Were au	topsy findings available completion of cause of	
The I	EO								autor perfo	rmed? 2 X No	death?		
cian: ertific ector,	Be (25. Was case referred to medical examiner?				1 -		of Death	(Check only o				
hysic this c	မ	1 ☐ Yes 2 No		tient 2 ER/Out			4 XI NUI				6 □Other (Spec	cify)	
Jing F	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. T ay Year) Ir	njury M	8c. Injury a Work?	at ? es 2∐h		3d. Describe I	now inju	ry occurred		
deati deati ctor: y the	flca	2 Accident investigatio 3 Suicide 6 Could not b	njury - At home, far	arm, street, factory, office 28f. Location					(Street and Number or Rural Route Number,				
after Dire	Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)											
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical () and manner as d place, and due	stated. to the cause(s)		
thin 2 the I mplet	Med	one) 29b. Signature and title of certifier	290					29d. Da	9d. Date signed (Month, Dey, Year)				
5.½ 5 8	_	+ 1 al . mo				D55455				10	10/22/09		
		30. Name and address of person who	completed cause of	death (Item 23a) (000	40.	<u> </u>		10	x/ds/	0 /	
BS/10			Fatima Hussein, M.D. 5625 Allentown Rd. Suite 101, Camp Springs, MD										
Sta Regist		31. Date filed (Month, Day, Year) DEC 28 2009 Server B. Januar											
- realist		The Same of the											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43217 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Beverley Ann Headly 2009 4:15 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13006 Tamarack Road Silver Spring Montgomery 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Guyana 1 🗆 M 2 🗓 F Months Hours Min. July 27. **Director** 216-23-2395 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Montgomeru Silver Spring Maruland 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 13006 Tamarack Road 20904 u.s.A. or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married 2 X No 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o ည Lyndon Alonzo Bennett Lucille Euranie Bone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13006 Tamarack Road, Silver Spring, Maryland 20904 Gregory Headly - Husband injury or other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 12/31/2009 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Wal 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastic Breast Cancer Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions if any, leading to immediate cause. Enter Underlying the attending physician and hed for use as the burial-transit Cause (Disease or linjury Hupertension that initiated events Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 4 Pregnant Pregnant at time of death Other (specify) signed by the a 1 ☐ Yes ∠ A Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. injury 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month. Day, Year)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O. I

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Bone, M.D.,

31. Date filed (Month, Day, Year)

D46285

10905 Ft. Washington Road, Suite 206, Ft. Washington, MD

December 23. 2009

		1 - State of Maryland / Dep	partment of Health and ertificate of Death		ene gg. No. 2009 43218
		Decedent's Name (First, Middle, Last)	The state of the s	2. Date of Death	3. Time of Death
Physici Medi		Charles E. Hutchinson		Month December	Day Year
Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
		Holy Cross Hospital	Silver Spring		Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,)	9. Birthplace (State or Foreign Country) 134 Maryland
		219-34-7729 75 Yrs. Usual Residence of Decedent		1 2/10/19	34 Maryland
land shov dat	ţō	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Mary 28a-f otifie	Director	MD Anne Arundel Lau	rel		1 🛣 Yes 2 🗆 No
h the Maor	<u>=</u>	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Country?
th wit ns 23 must	Funeral	10 N. Carol St.	20724		USA
r deal		Attrica Foldas:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
036 s afte "al", c	d by	KVa Ohn	1 ☐ Yes 2 🙀 No Specify:		Specify: White
Ind 21215-0036 filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	1	16b. Kind of Business Industry
21, in 72 e. han "	Į į	(Specify only highest grade completed) (Giv. Elementary/Seconday (0-12) College (1-4 or 5+)	e kind of work done during most of wo DO NOT use retired)	rking	
21 with ygien ygien it, the	Be C	11100	r Installer		Private
and e filed ntal Hy ed oth	10 B	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	•
ryling bould bould bould bound	ľ	James Earl Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Eleano	~	Hutchinson
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on princing or other traumatic event, the Medical Examptoe.			ling Address (Street and Number or Ru		20724
Baltimore, I permit. Page 1 and 5 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 20b. Place of Disp	osition (Name of	el, MD.	20724 20c. Location - City or Town, State
IMOF Page 1 ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 ☐ Fort Li	ematory or other place)	31/09 B ₁	montreed MD
Baltim permit. Pag Department Important: any injury c			22. Name and Address of Facility Fo1	t Lincolr	rentwood, MD.
n 225 5	(1)	reta marcis :	3401 Bladensburg B	ld. Brent	twood, MD. 20722
		23a. Part 1. Enter the diseas , * complications that caused the death. Do not er shock, or heart failure it only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between
Prysician		Immediate Cause (Final disease or conditiona Cardiopulmonary A	rrest		Onset and Death
Medical Examiner	_	Due to (or as a consequence of):	71-72-114-15-1		
	ē	Sequentially list conditions, if any, leading to immediate	'ailure		
ted I nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury Congective Heart	Failure Cardiomy	onathy	
be executed sician and burial-transii	Ë	that initiated events resulting in death) Last C. Due to (or as a consequence of):	rarrare, oararom,	opacity	
ords, P.O. Box 68/60 v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d			
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that the ned by t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
S, I	d by	Hypotension		1 🗆 Yes	s 2 No 3 Probably 4 🕱 Unknown
ord v requ	lete	Hypercapnea		24a. Was an	24b. Were autopsy findings available
he lay te has	Completed			autopsy perform 1 \sum Yes 2	ed? death?
ian: T	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che	-	20 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
VIT hysic hysic his ce	2	1 ☐ Yes 2 🖾 No Hospital: 1 😿 Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing I	lome 5 🗆 Resider	nce 6 Other (Specify)
Ing P	Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 28a. Date of injury injury	work?	28d. Describe how	v injury occurred
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DIVISION OT VITAI HECONGS, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be an incompanion.		4 Homicide determined building, etc. (Specify)	reet, ractory, office	City or Town,	eet and Number or Rural Route Number, State)
Spita hours neral	ical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occured at the time, date and place,	I and due to the cause	e(s) and manner as stated.
DIVISION OF VITAL RECORDS, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invenience only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred death occurred at the time, date and pl	at the time, date and ace, and due to the c	place, and due to the cause(s) and manner stated. ause(s) and manner as stated.
vith vith com		29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
		Sollie M.D.	D0064100		12/23/09
10 10		30. Name and address of person who completed cause of death (Item 23a) (Type,	*		00010
Sta	to.	Smitha Bhikkaji, M.D. 1500 Forest 31 Date fled (Month, Day Year) 32 Registra's Signature	Glen Road Silver	spring,	MD. 20910
Registr	ar	31. Date filed (Month, Day Year) 32. Registrate Signature 33. Date filed (Month, Day Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 25, 2009 **Physician** 2/13 M Jackson Althenia Healey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 14800 Pennfield Circle, #205 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 X F 386-34-1441 73 Director Nov. 10,1936 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 TYes 2 □ No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re 20906 14800 Pennfield Circle, #205 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Payroll Coordinator U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked o Frank Healey Emmie Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lee Jackson/Spouse 14800 Pennfield Circle, #205 Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or 12/29/2009 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. any 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician m (disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linery that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transi Exami and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Por Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsv perform certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2Z No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I Within 24 hours after death.
To the Funeral Director: After Injury Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

mo Done

In DME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

ECKER,

32 Registrar's Signature

29c. License number

1000428

Silvei

29d. Date signed (Month, Day, Year)

Dark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 5 per fh 8899 1-21-10 vt
State of Maryland / Department of Health and Mental Hygiene
Amend #5, per fh 6899 1/25/10 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chery1 Jervis Α. 2009 10:19 AM Dec Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 213-58-6693 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XX (Month, Day, Year) Months Days Hours Min. Washington DC Director 213-56-66 58 June Usual Residence of Decedent or 28a-f show 10a. State 10b. County should ite filed within 72 hours after death with the Maryland han Michael Hyglene. It is a racked other than "natural", or items 23a or 28a-f sho its arked other than "natural", or items 23a or 28a-f sho its are went, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4707 King John Way 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4XX Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 +4 Certified Public Accountant Health Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen Mcelveen W. McGary Arliene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If item 27 is Teasley- Daughter 911 Viburnum Road Apt. 102 Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. 5 permit. Page Department of Important: If any injury or Lee Crematory Dec. 27,2009 Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility M01533 Lee Funeral Home, Inc. 01dAlexandria Ferry rd, Clinton, MD 20735 23a. Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mo, e of dying, suc-only one cause on each line. Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year been signed by the should be detached 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner Hospital: Other: ဂ္ 1 Yes 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5
Pending ☐ Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) on who completed cause of death (Item 23a) (Type, Print) 0 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23 Jones 2009 5:30p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3300 Ryan Drive Suitland Prince George's 8. Date of Birth (Month, Day, Year)
Jan. 20, 1944 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Months Davs 1 ₽M 2 □ F 578 56 1138 Director 65 Yrs WashingtonDC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐Yes 2 ☐ No MD Prince George's Suitland the ! 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Drive Ryan 20746 US Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Jones Mary Clifford McHenry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Jones/wife Suitland, MD 20746
Date | 20c. Location - City or Town, State <u>3300 Ryan Drive</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Resurrection Cem 4 ☐ Donation 5 ☐ Other (Specify) 1-2-2010 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington RD Waldorf, MD20601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (vi as a consequence of) for use as the burial-transit Exami Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year signed by the a 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ NO peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 / natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and tille of certifie

31. Date filed (Month

DHMH 17 Rev 1/2001

se of death (Item 23a) (Type, Print)

29c/ License number

29d, Date signed (Month, Day, Year)

and manner stated.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 1023 4M 12 5 6 /Medical 4a. Facility Name (If not institution, give street and humber, 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. 74 015-28-7685 Director 8/08/1935 Canada Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Eventian 11 ust be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits N.H. Cheshire Spofford Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 871 Route 63 03462 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: \$ White Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u> Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Omer Vadnais Adele Nadeau ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline L. Price/daughter 281 Highland Avenue Pittsfield, MA 01201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 Removal from State Ashuelot Cemetery 12/30/2009 Dalton, MA. 4 ☐ Donation 5 ☐ Other (Special 22. Name and Address of Facility DERY FUNERAL HOME 54 Bradford Street Pittsfield, MA 01201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASTROINTESTINAL HEMDARH ALE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASTAO ESOIHAGEAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 ☐Yes 2 ☐No 2 🗆 No Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2☐ ER/Outpatient 3☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 1009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WA 20 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State		State of Ma	arylan	-	artment of H tificate of L		nd Me	_	•	2000	1 2	222
			Registrar 1. Decedent's Name (First, M	ddle, Last	·)		Cer	Tillicate of L	Jean	2	. Date of Dea	Reg. No	.ZUU`	3. Time o	C C S
	Physicia Medic		Gladys		Ε.	J	оусе			1	Month ecembe	-	¥, 2009	11:00	
	Examir		4a. Facility Name (if not institu 308 Aragona I		street and number)			4b. City, Town, or Ft. Wa	Location of E			40	County of Dea	th George	s
	Funeral Director		5. Social Security Number 316-40-3067		× □ M 2 🔀 F 7. Age		st birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8 Min.	Date of Birt Month Da 06/19/		9. Bi	thplace (State country) Englar	or Foreign nd
	nd how at		Usual Residence of Decedent 10a. State 10b. Co.			10c. City	Town or Lo	cation					***	10d. Inside C	
	Maryla 28a-f s atified	rect	Maryland Prin	ce Geo	rge's	Ft.	Washing	ton							2 XX No
	with the s s 23a or 2 ust be no	Funeral Director	10e. Street and Number 308 Aragona D	rive				10f. Zip Code 207	744			10g. Ci	tizen of What C	ountry?	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	含	11. Marital Status 1 ☐ Never Married 2 ☐ 3XX Widowed 4 ☐ Divo		12. Was Decedent E Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates.			Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 XXNo	n, Mexican, P	? (Specify uerto Ric	/ Yes or No- an, etc.)		14. Race - Ame Black, Whit		
5-0	2 hour	plet	15. Dec (Specify only h	edent's Ed ighest grad			16a. Dece	dent's Usual Occup	ation during most of	f workina		16b. K	and of Business	Industry	
12121	d 2 should be filed within 72 lath and Mental Hygiene. 127 is marked other than "r traumatic event, the Med	Be Completed	Elementary/Seconday (0-1 12 years		College (1-4 or 5	+)	life. D	O NOT use retired) enaker					In Home		
yland	uld be file Mental H narked of ratic ever	ToB	17. Father's Name (First, Midd George H.	Wilc					18. Mother's Edit			Maiden Ielps	,	_	
, Mar	nd 2 shouealth and m 27 is maner traum		19a. Informant's Name/Relati David Joyce					ng Address (Street a Newkirk							
Baltimore, Maryland 21215-0036	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremat 4 ☐ Donation 5 ☐ Oth			ce	ace of Dispo metery, cren AS Crem	sition (Name of natory or other plac Btory	e) De	Date c.31	,2009		ocation - City or ewater, M		
Balt	permit. Depart Import any inj		21. Signature Juneral Servi	ce License	е	•	6.	. Name and Addres 160 Oxon Hi	ss of Facility 11 Road	Geor Oxon	ge P. K Hill, M				
			23a. Part/1. Enter the disease shock or heart failure. L Immediate Cause (Final	e, or compl ist only on	e cause on each line				g, such as car	diac or re	espiratory arr	est,		Approximat Interval Bet Onset and I	ween
,	Physician/ Medical	1	disease or condition resulting in death)		Atria Due to (or as a		orilla ence of):	tion						Oriset and t	Jean
	Examiner	<u>.</u>	Sequentially list conditions,	1)			Coronar	y Arte	ry D	isease				
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	<	Hyper										
_	be execu sician and burial-tra	cal Exa	that initiated events resulting in death) Last		Due to (or as a Folli		ence of):	homa							
3760	ificate ig phys as the	Medical	IF FEMALE:		d										
Division of Vital Records, P.O. Box 68	lor Attending Physician: The law requires that the death certificate be executed after death. after death. In by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	у				23d. Date of de Month		'ear
s, P.O	ires that the signed by do be detact	þ	Part II. Other significant con	ditions cor	ntributing to death bu	it not resul	Iting in the u	nderlying cause giv	en in Part I.				use contribute to		
ord	w requ	plete									24a. Was a	an	24b. Were au	topsy findings a	vailable
II Rec	sician; The la certificate ha irector, page 2	Sompleted	25. Was case referred to medi	cal				00 DI	(D. H. (autop perfor 1 Yes	med?	death?	completion of ca	ause of
VIII 3	nysicia nis certi directo	To Be	examiner? 1 ☐ Yes 2 No		ospital:	nt 2 🗆 E	R/Outpatien	Otho	r: 4 Nursir			ence 6	Other (Spec	ifv)	
on of	anding PP sath. or: After the ne funeral	Certificate:		estigation	28a. Date of injur (Month, Day,	Year) 2	28b. Time of injury	28c. Injury work' M 1 □	at	28d	. Describe ho				-
DIVISI	tal or Atter safter de al Directo			uld not be ermined	28e. Place of Injur building, etc.		ne, farm, stre	et, factory, office		28f.	Location (St City or Town		d Number or Ru	ral Route Numb	er,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the to	Medical	29a. Certifier 1 Certify (Check 2 Medic only one) 3 Certify	ing Physic al Examina ing Nurse	cian: To the best of ner: On the basis of ex Practioner: To the b	ny knowled amination a est of my l	dge, death o and/or invest knowledge, d	ccured at the time, gation, in my opinio eath occurred at the	date and place n, death occur e time, date and	ce, and dured at the	ue to the cau time, date ar nd due to the	ise(s) an nd place, cause(s	d manner as sta , and due to the s) and manner as	ted. cause(s) and mar stated.	nner stated.
-	vitt Com		29b. Signature and title of cert		1			29c. License	number			29d. Dat	e signed (Month	, Day, Year)	
R	20		30. Name and address of pers	on who co	mpleted cause of de MD 6357 C	ath (Item 2	3a) (Type, P	rint))14760 Mary Jan	- J	07/F	rece	ember 28,	2009	
	Stat Registra	e	31. Date filed (Month, Day, Yea		32. Registrar				nor Argri	iu Z	0745				
					7 /										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December. 2009 2151 John Albert Klickna. II Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Illiviois 1 🛛 M 2 🗆 F Months Hours Min 08/06/194 63 Director 354-36-1695 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD North Potomac 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funeral 12741 Triple Crown Road 20878 U.S.A items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 'natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 1970 Specify 3 Widowed 4 X Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Health Care Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked John Albert Klickna. I Marjorie A. Van Ormer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Klickna - Son 12741 Triple Crown Road, Gaithersburg. MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 12/30/2009 Metropolitan Crem. Alexandria, VA 21. Signature of Fobera Service Licensee 22. Name and Address of Facility Simple Tribute Funeral Home any 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death
Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lung Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Were autopsy findings available prior to completion of cause of death? Severe Anemia 24a. Was an autopsy 2 X No 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 1 Tyes 2 🗶 No 1 Hopatient 2 ER/Outpatient 3 DOA Certificate: To 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Machan

Madhavi Hubbly.

DEC 30

Hubb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D62562

9901 Medical Center Drive. Rockville. MD 20886

29d. Date signed (Month, Day, Year)

December 28, 2009

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 28, 2009

32 Registrar's Signa

recen

OCME

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dan Jua1 Kennedy Dec 2009 9:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital 8. Date of Birth OCT 4, 1933 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Min. Hours Virginia 579 44 6664 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 XXNo Prince George's MD Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5000 Lydianna Lane 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 10th College (1-4 or 5+) **US** Sentor Messinger Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Carl Kennedy Ruth E. Denton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kennedy (WIfe) 5000 Lydianna Lane, Suitland, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dec 30, 2009 Clinton, Maryland Crematory 21. Signatur of Funeral Sovice Ligensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ongretive disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death
Unknown signed by the a d be detached f by the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATVIZ within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed' 25. Was case referred to medical 1 ☐ Yes 2 ☑ No Yes 2 2 No 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Signatu

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	1 - State of Maryland / Dep	artment of Health and Mer ertificate of Death	ntal Hygiene 2009 43227
	1. Decedent's Name (First, Middle, Last)		Date of Death 3. Time of Death
Physician	Jeffery Edward Kauffman	D	Month ecember 24, 2009 5:15 p M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laminer	1/621 Proceed on Man	Marsh Data	Montgomory
Funeral	14631 Brougham Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	North Potomac If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	212-68-0772 1XD M 2 F 52 Yrs.		(Month, Day, Year) Country) 6/6/1957 Washington D.C.
	Usual Residence of Decedent		Washington D.C.
/lanc	10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
Man,	MD Mantagana Nanth Day		1 XYes 2 No
the 28a	MD Montgomery North Por	10f. Zip Code	10g. Citizen of What Country?
with Lbs	1/621 P	20070	77.0
fter death with the Mar fter death with the Mar ritems 23a or 28a-f st the rough be notified for the death of the coor	14631 Brougham Way 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify	VSA vYes or No- 14. Race - American Indian,
iter d	Armed Forces? 1 □ Never Married 2 🛣 Married 1 □ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	an, etc.) Black, White, etc.
irs af	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐Yes 2X No Specify:	Specify: White
bou Et a		edent's Usual Occupation	16b. Kind of Business/Industry
ed within 72 hou ygiene. The Medical Et. The Medical Et. The Medical Et.	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	Tob. Talla of Basilloss makery
withii withii than	Elementary/Secondary (0-12) College (1-4or 5+)	aphic Designer	Hote1
in the Hyging	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)
ibe fill that he ed out		Mildred La	
natic	Albert Gerald Kauffman		•
VICE ST IS S			oute Number, City or Town, State, Zip Code) Potomac, Maryland 20878
d, and lealt mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm			20c. Location - City or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, he Medical Exercitive must be nuitified at once. To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place of Disposer 1	ematory or other place)	
tant: Jury	4 □ Donation 5 □ Other (Specify) Judean	Mem. Grds 12/27/2	
permit Depar Impor any in	21. Signature of Funeral Service License Melissa Greenhut MO159	22. Name and Address Baraird Sag	el Funeral Direction, INC
20589	1 Collothelens 1	091 Rockville Pike,	Rockville, Maryland 20852
	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	Interval Between
Physician	Immediate Cause (Final disease or condition Matastatic Ren	al Cell Cancer	Onset and Death 3 Years
/Medical	resulting in death) Due to (or as a consequence of):		
Examiner			
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
executed in and ial-transit	Cause. Enter Underthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
exertial-tr	resulting in death) Last Due to (or as a consequence of):		
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nat the death certificate be do by the attending physici tetached for use as the bu Physician/Medical	_		
eath certificate attending for use as	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
death death of for differ diff	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
by the detached	9 Unknown		
that that dete	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
uires t uires t signe Id be			1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown
The law requir cate has been s page 2 should			24a. Was an 24b. Were autopsy findings available
ne lav s has ge 2			autopsy performed? death?
ian: The Later hastor, page ator, page			1 ☐ Yes 2 📉 No 1 ☐ Yes 💥 ☐ No
Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as: TO BE Completed by Physician/Me	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (C	heck only one)
To To	1 Inpatient 2 ER/Outpatie		5 ₹ Residence 6 ☐ Other (Specify)
	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day, Year) Injury	Work?	. Describe how injury occurred
Attending r death. ector: After by the fune fine fine	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 290 Place of Injury. At home, form of	M 1 ☐ Yes 2 ☐ No	
tal or Attending F rs after death. al Director: After led in by the funers Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending within 24 hours affect death. To the Funeral Director: After the American Street of the Funeral Director: After the American Street of the St			
t hou though the hour three sely file sely file cal	29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred a	I due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
the Hosp ithin 24 hou the Fune mpletely fi	one) and manner stated.		
P P P	29b. Signature and title of certifler	29c. License number	29d. Date signed (Month, Day, Year)
100	· jane france mo	D0061083	December 26, 2009
	30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	Dealers 110 Manual and 20050
	Paul M. Thambi, MD 9707 Medical Cent	er Drive Suite 300 l	xockviiie, maryiand 20000
State	31. Date filed (Month, Day, Year) 22. Registrar's Signature	Ked.	
Registrar	DEC 2.9 2009 12 20 13. 100	CONT A	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 December William Edmund Leight 2009 5:47 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 227 South Fork Dr. Hagerstown Washington County 8. Date of Birth (Month, Day, Year) July 30,1940 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours Min. 220-36-4458 69 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Expresser must be retilled at Maryland Washington County 1 ☐ Yes 2 XNo Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 South Fork Dr. 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 XWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Office Equipment Co. Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edmund Leight, Jr. Doris M. Ellis Ketland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher W. Leight-son 102 Emily Way SMithsburg, MD 21783 20b. Place of Disposition (Name of cametery, crematory or other place).
Rest Haven Memorial Gardens 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1-2-2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or held failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) uconou /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🗖 25. Was case referred to predical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of . Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stat e and title of certifier 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, [11 IIII Grede th w

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BETTU HOASOL 9 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Bethesda Health & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 9 / 1.5 / 1.9 2.9 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 M 2 Tr Months Bolivia Yrs 227-63-1898 80 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Silver Spring **Funeral Director** MD Montgomery 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3952 Bel Pre Road #5 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ¹⊠Yes 2□No *Specify:*Bolivian þ White Specify 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk. Crespo ဂ Jose Vera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5634 North 6th Street Arlington, Va. 22205 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is · David Lozada/Son Department of Health Important: If item 27 any Injury or other troops. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 DeBurial 2 □ Cremation 3 □ Removal from State 12/30/2009 Silver Spring, MD Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) PHITE TPACE SERVICE, P.A. 21. Signalure of Funeral Service 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Ent.: the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MUOCARDIAL NRARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUPBRIBNSION MELLITUS, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown STAGE RENA PERIPHLIKAL VASCULAR DISALP4a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No autopsy performe GAN GILLING CONGESTIVE MENT 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation n 24 hours are: he Funeral Director: Af 1 TYes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To th. within 24.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

5530

32. Registrar's Signature

CJANDOUDIA

Medical

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

MISCONSIN

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AVE.

29c. License number

D 17656

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29d. Date signed (Month, Day, Year)

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CNASE

WAND

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certific

one)

Registrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abdul Munim, MD LRH- 7300 Van Dusen Road Laurel, Maryland 20707

29c. License number

D55861

29d. Date signed (Month, Day, Year)

December 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** NEUSOH 2009 MAYNARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. HOME James 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F 64 08-10-1945 Maryland Director 217-44-1578 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 Yes 2 No Director Md. Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8 St. James Ct. 21601 USA by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 DYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Landscaper/Boatbuilder Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maynard Winslow Lowery Myrtle Helen Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. James Ct., Faston, Maryland 21601
Disposition (Name of Date 20c. Location - City or Town, State <u> Mary Helen Lowery / Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Direct Crematory 12/30/2009 Dover, Delaware 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State A □ Donation 5 □ Other (Specify) 21 Sign Lor of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION FEW **Physician** SUSPECTO Honr /Medical Due to (or as a consequence of): Examiner YEARS HYPERTENSION MAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be c Completed by 3 Probably 4 □Unknown 2□ No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√ No 24a. Was an page 2 s autopsy performed? 1□ Yes 2X No this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0069348

3

Registrar

State

MNNABELLE

31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 28 2009

MW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHESAPEA

CAMBRIDGE

	1 - State Registrar			Certificate of	Death	d Mental H	Reg. No	2000	4323
huo ini	1. Decedent's Name (First, Mic	ddle, Last)				2. Date of D	-		3. Time of Deat
hysician /Medical		James Free	deric	Lohman		Decem		31, 2009	0835
xaminer	4a. Facility Name (If not institut			4b. City, Town, o	r Location of De	eath	40	c. County of Death	
	7460 Todd 5. Social Security Number	Wharf Roa	ad Age <i>(In yrs. last bir</i>	Prest	On If Under 24 F	rs. 8. Date of B		Caroline 9 Birthr	place (State or For
ral tor	287-20-2872	1 🕅 M 2 🗆 F		Yrs. Months Days		in. 04/30	71922	Indi	ana
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Funeral Director	Maryland (Caroline		Preston 10f. Zip Code			10g. C	itizen of What Cour	
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를 돌 교	1 Never Married 2 M	larried 1 ☐ Yes 2 🛚 If Yes, Give] No	1 □Yes 2 No	Specify:	orto riioari, oto.,	ĺ		
Completed by	3 Widowed 4 Divorce	ed Year or Dates lent's Education		Decedent's Usual Occur	pation		16b k	(ind of Business/In	ucasian
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Be	17. Father's Name (First, Middl				l _' ' ' '	lame (First, Middl	e, Maidei	,	
2	Maurice Rober				Bernice			Bipp	
	19a. Informant's Name/Relatio Charles W. Les	nship (Type. Print) slie/Companion	1 & P.R. 7	. Mailing Address <i>(Street</i> 460 Todds W	and Number or harf Rd	, Prestor	ber, City 1, MI	or Town, State, Zip) 21655	Code)
once.	20a. Method of Disposition		i comotor	f Disposition (Name of ry, crematory or other place	ce)	Date	20c. L	ocation - City or To	own, State
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		eı	tol Cremator	: 10	/31/2009	Do	ver, Dela	aware
once.	21. Signature of Funeral Service	(A)	,	22. Name and Addre	ess of Facility N	loore Fun	era1	Home, P	.A.
a	* Kanagin	1110m		12 South S	second S	treet, D	ento	on, Maryla	and 216
		or complications that causist only one cause on each	ed the death. Do r line.	not enter the mode of dyli	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between
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29c. License number

463519

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Point looker Rd Leonard trag MD 20650 25500 31. Date filed (Month, Day, Year) D. T-LKU. DO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ED Physician

Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. Cou			1	For State Registrer	State	of Mary	land		artmen rtificat			nd Me	ental Hy	giene Reg. No.	_ U U	9	43234
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of bertifier 29b. Signature and title of bertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Certifier 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Certifier 29d. Date signed (Month, Day, Year) 29d. Certifier 29d. Date signed (Month, Day, Year) 29d. Date	ords, P.		2	Part II. Other significant condition	ons contributing t	o death but r	not resul	ting in the u	nderlying o	ause give	en in Part I.		1				
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30. Name and address of person who completed cause of poath (Item 23a) (Type, Print) RICHES (FINAL PERIOD DECIL RE, KING GEORGE, VA 22 485) State 31. Date liled (Month, Day Year), 2000 32. Registrar's Signature	Division Attents after de el Directo		Certific	dotom	ined 280. Pl	ace of Injury uilding, etc. (- At hor (Specify)	ne, farm, st	reet, factor	y, office		2	8I. Location (City or To	Street ar wn, State	nd Number e)	or Run	al Route Number,
State 31. Date liled (Month, Par Year) & 2000 32. Registrar's Signature	To the Hospi within 24 hour To the Funer		edical	(Check only 2 Medical one)	Examiner: On the	e basis of ex	camination		vestigation 29	c. Licens	pinion, death e number			date and	d place, an	d due t Month,	Day, Year)
	B 4	State	e	RICHAS KEIN	17664 1	FERRY	Dic.	1 Pd		N6	6 FOR	CE,	VA .	224	185		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ РМ 2009 Laura Etta Long December 14:38 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Min. August 30 Months Days Hours 1949 Wash Director 212-54-1655 60 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles Waldorf 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? nt of Health and Mental Hygiene.
It if item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be o by Funeral <u>426 University Drive</u> 20602 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Washington Post Distribuitor 12th Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 <u> William Clifton Sweet, Sr</u> <u>Shirley Elizabeth Sweet</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 William Sweet, Sr./ Father 8105 Poplar Hill Dr. Clinton, Maryland, 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Trinity Mem. Gardens Dec. 26, 20Q9 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Huntt Funeral Home D00083 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ Acute Reportory ue to (or as a consequence of): disease or condition resulting in death) Failur Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam requires that the death certificate be executed ohstru attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) een signed by the nould be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s Hospital or Attending Physician: The law After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 2 X No 1 🗌 Yes မ 1 Pupatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending the Funeral Directo. 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Declining Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

completed

within 2 To the F

29a. Certifier

(Check

31. Date filed (Mo

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

strar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 12/22/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2009 Robert Arthur Lindsay Dec.24 9:45pm^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, 1 🔀 M 2 🗆 F Director 242-66-5809 66 Nov. Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director or 28a-f s notified MD Montgomery Silver Spring 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral USA 11802 Mentone Road 20906 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1964 Black, White, etc. 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Research Park Be Page 1 and 2 should be filed ment of Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abram Lindsay Luzenia Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ida Olivia Lindsay/Wife 11802 Mentone Road Silver Spring, Md 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 😾 Removal from State New Smith Grove 12/30/2009 Lexington, N.C. 4 Donation 5 Other (Specity) PHYDE ADSTINALDI FUNERAL SERVICE, P.A. 21. Signatur Fu eral Se Nice 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Postobstructive pneumonia Medical resulting in death) Due to (or as a consequence of): **Examiner** 1week Non-small cell lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical the as USe 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s certificate has performed? Yes 2X N 1 ☐ Yes 2 ☐ No **Division of Vital** funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 은 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural iniury 5 \square Pending 24 hours after death. Funeral Director: Al 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide within 24 hours after de

To the Funeral Directo

completed filled in by the 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a, Certifie 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) + MD 00066990 0 3 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinni Juneja MD

State

31. Date filed (Month, Day, Year,

DEC 29

174:

Lindsaw,

Rockledge Drive Bethesda,

Md 20817

6420

2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nancy Mary Muller 6:55P. December 24, 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 9006 Laurel Bowie Road Prince George's Bowie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □XF 76 Months Hours May 1933 OHIO'' 405-46-7079 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's Bowie 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9006 Laurel Bowie Road 20720 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul McDonough Agatha Wespiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 Laurel Bowie Road Bowie, Maryland 20720 Gerald F. Muller -husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/29/2009 Alexandria, Virginia 21. Signature of Funeral Service icensee Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death signed by the a d be detached t 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 X Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page death? After this certificate 1 Yes 2 XNo æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 XNo ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of certifie 29c. License number 29b. Signature and ti 29d. Date signed (Month, Day, Year) D45660 December 28, 2009 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Dpinder Singh,
31. Date filed (Month, Day, Year)

DEC 30

MD 14300 Gallant Fox Lane Bowie, Maryland 20715

State of Maryland / Department of Health and Mental Hygiene Amended, #20b, 1 - State Registrar TCHD, 12/21/2009, TLS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Mouring Edward James December 15 /Medical give street and number . Facility Name (If not institution, 4b. City. Town, or Location of Death Examiner ambridae senera 8. Date of Birth (Month, Day, 06-14-Social Security Number or Foreign **Funeral** 1 M 2 □ F Months Hours 220-74-6461 60 Director Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location or items 23a or 28a-f show Injury or other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 TNo Director Dorchester Hurlock Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21643 4841 Williamsburg Church Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Black 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Delmarva Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other this any finjury or other traumatic event, this once. Community Center Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane Myrick Addie Mouring ٥ Roosevelt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4432 Harmony Road, Preston, Md. 21655 Bernanette Velez /Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/21/2009 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Thompsontown Cem. 12-19-09 Hurlock, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dreumon ASPIRATION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 sl 24a Was an 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2 No 2 KER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not he 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RS 1 Malking 408 31. Date filed (Month, Day, Year) 32. Registrar's Signaju State **DEC 21** 2009 Registrar

DHMH 17 Rev 1/2001

			For State		State	of Marylar		artment of H tificate of L		nd Menta	, -	0.0	0.06	100	1. 0
5 K			Registrar 1. Decedent's Name	(First, Middle	, Last)				Jean		e of Death	eg. No.	1113	3. Time of D	
4	Physici /Medic		661				W.	NTges			en-6			19:38	PM
1	Examin	er	4a. Facility Name (If r			mber) -		4b. City Town, or Baltimore		Death		4c. Coun	ty of Death		
- 3	Funeral		5. Social Security Nu		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Dat Min. (Mc	e of Birth onth, Day,	Year)	9. Birthp	lace (State or i	Foreign
âz	Director		217-34-132 Usual Residence of D		1 M 2 X F		72 Yrs.	Monaro Bayo	riodio		12,		_	INGTON	D.C
	laryland show dat			10b. County		10c. Ci	ity, Town or Lo	cation					1	0d. Inside City	
	ne Mar 28a-f s tiffed	Director		TALBOT		EAST	CON							1 XYes 2	2 🗌 No
	with the		10e. Street and Numl					10f. Zip-Code 21601				og. Citizen of	t What Coun	try?	
	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. • marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	LAVE	12. Was Dec	cedent Ever in U		Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	in? (Specify Yes	s or No-	14. Ra	ace - Americ ack, White, e		
36	s after ', or it	by Fu	1 ☐ Never Married 3 ☐ Widowed 4			ve 2X No		l □ Yes 2x No	Specify:	T donto ritodin, c	,,,,	Spec	cify:		
5-0036	2 hour atural' cal Ex	ted k		15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation	a f v v a skia sv	1	16b. Kind of	WHIT Business/In		-
21218	ithin 7 ne. nan "n	Completed	Elementary/Secon		College (1-4 or 5+)	life. L	kind of work done on NOT use retired,))	or working		OT DIT	поме		
2	be filed wil		17. Father's Name (Fi				HOMEM	AKEK	18. Mother	's Name (First,	Middle, N		HOME ame)		
Maryland	should be nd Mental marked o	To Be	RICHARD W.	FISH	ER				HAZEL	ATHEY					
lary	2 should and Iversity mainstance.		19a. Informant's Nam	ne/Relationsh	nip (Type. Print)			ng Address (Street				•		Code)	
	s 1 and 2 should be filed within 72 hours after death with the Mai if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 s other traumatic event, the Medical Examiner must be notified		JAMES A. N 20a. Method of Dispo		s, JR./HU	20b.	Place of Dispo	CASEY AVE		STON, M		AND 21 20c. Location		wn. State	
altimore,	Pages nent of nt: If It			Cremation	3 Removal from	State	cemetery, cren	natory or other plac		2/27/20					
	permit. Pages Department of Important: If it any injury or once.		21. Signature of Fune	ral Service Li	icensee	1 7411	22	. Name and Addres	ss of Facility						
8	호스 트 등 이		23a. Part 1. Enter the	disease, or o	complications that	caused the deat		LLOWS, HE						Approximate	
	Physician		shock, or heart to Immediate Cause (Fin	failure. List o	nly one cause on	ach line.		yperter					1	Onset and De	een eath
1	/Medical		disease or condition resulting in death)		a. Due to	(or as a consec	quence of):	The less	1-1-						
	Examiner	e	Sequentially list cond	litions,	b	(or as a consec	ujence čir								
	uted 1 ansit	Examiner	cause. Enter Underly Cause (Disease or in that initiated events	ying 🥌	c	(0. 0.0 0.000	, 20.100 0.,								
o,	be executed sician and burial-transit		resulting in death) La	st	Due to	(or as a consec	quence of):								
8760	cate phys	edical			d										
9 X	eath certifi attending I for use a	M/us	IF FEMALE: 23b. Was decedent p	regnant		tcome of pregn		Tetania programa				23d. D	Date of delive	ery	
Box	e death	Physician/M	in the past 12 m 1 ☐ Yes 2 X 9 ☐ Unknown	onths? No		nant at time of o		Ectopic pregnancy Other (specify)	у			V	<i>f</i> ionth	Day Ye	ear
P.O.	w requires that the death cert been signed by the attending should be detached for use		Part II. Other signific	ant condition	ns contributing to	death but not re	sulting in the u	nderlying cause giv	ven in Part I.	. 23	e. Did tob	acco use co	ontribute to t	he cause of de	eath?
Records,	quires n signe	ed by					-				1 🗌 Yes	s 2 No	3 🗌 Prob	ably 4 □ Ur	nknown
ဝ၁	law re	Completed								24:	a. Was an autopsy	/	prior to co	psy findings a mpletion of ca	vailable use of
	- m		25. Was case referred	t to modical					00 Bl		perform Yes 2	No	death? 1 🗌 Yes	2 🗌 No	
<u> </u>	ysician: The sertificate director, pa	To Be	examiner?		Hospital:	Inpatient 2	ER/Outpatien	t 3 □ DOA Othe	or.	of Death (Check sing Home 5			ther (Specif)	······································	
Division of Vital	ding Phys th. After this tuneral d	iio	27. Manner of Death	5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	Work	₹?		scribe hov	w injury occi	urred		
1810	Attending Physician: or death. ector: After this certific by the funeral director.	ficati	2 Accident 3 Suicide	investiga 6 Could n	ot be 28e Plac	e of injury - At he	ome, farm, stre	M 1 1 1 1 cet, factory, office	Yes 2 □ N		ation (Str	reet and Nur	mber or Rura	al Route Numb	eer,
2		Certification:	4 Homicide	determir		ling, etc. (Specif					or Town,				
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f				Examiner: On the I	pasis of examina		occurred at the tin restigation, in my o							
	o the l	Medical	29b. Signature and tit	le of certifier	and ma	nner stated.		29c. License	number		29	d. Date sigr	ned (Month, i	Day, Year)	
	TLS		Muni	7 Jul	OH MD			RES	-000		1	recen	nter	15,26	09
	20		30. Name and address	s of person v	who completed car	use of death (Ite	m 23a) (Type,	Print)		200 Naw	. Walf	o C+ D	altima-	o MD o	1207
	Sta		31. Date filed (Month,			Rogistrar's Signa	ature	4		600 North	I VVOIT	e SI, B	aiumor	e, IVID, 2	.120/
	Registra	ar	n	FC 28	2000		A Su	arke							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar TCHD, 12/28/2009, TLS Certificate of Death Amended, #19a 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** \mathbf{P}^{M} DECEMBER 22, 2009 1:30 VIRGINIA MAY MENDE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MALLARD BAY CARE CENTER CAMBRIDGE DORCHESTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🕶 F Director 72 AUG. 29, 1937 PENNSYLVANIA 185-28-9391 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show 1X Yes 2 □ No Director MARYLAND TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 amy injury or other traumatic event, the Medical Examinat must be no once. 705 DOVERBROOK ST. 21601 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No If Yes, Give Year or Dates: Completed by Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER FOOD SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ JAMES STEVEN CORBIN ANNA MCCULLOUGH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) WALTER PATRICK, JR./SON PATRICK WALTER, JR./SON 1111 RIDLEY CREEK, MEDIA, PA 19063 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition woodlawn MEMORIAL
PARK 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DEC. 30,2009 EASTON, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee WHOL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 18955 omolication disease or condition resulting in death) /Medical ue to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy performed 5+00011hr. 2 KNb 1 ☐ Yes 2 🗫 🗖 O ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Surring Home 5 Residence 6 Other (Specify) 2 [**X**Vo 1 Inpatient 1∐Yes 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number title of certifie n who completed cause of death (Item 23a) (Type, Print) me and ddress of 605 A

State

Registrar

31. Date filed (Month, Day,

Year)

28

100

32. Reofstrar's Signature

			1 - For State of Maryland / E		artment of He rtificate of D			R	eg. No. U) 9	43242
ı	Physicia		1. Decedent's Name (First, Middle, Last) John Michael Manning					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of	Death		4c. County	of Death	11:29a
			6029 Sunset Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	46-4	Tilghm If Under 1 Year	lan If Under 2	4 Hrs	8. Date of Birth	Tall		place (State or Foreign
ľ	Funeral Director		4CM 8CE	Yrs.	Months Days	Hours	Min.	(Month, Day 12-22-	, Year)	Md.	place (State or Foreign entry)
	and w.		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town	n or Lo	cation					1	10d. Inside City Limits
	Maryi	tor	Md Talbot Tilgh	nma	n						1 ☐ Yes 2 💢 No
	ith the	Direc	10e. Street and Number		10f. Zip Code			1	log. Citizen of	What Coul	ntry?
	a 23a	srai	6029 Sunset Lane 11 Marital Status 12. Was Decedent Ever in U.S.	12.1	2167		in2 (Sno	offy Von or No.	USA 14 Bac	a - Americ	can Indian,
036	be filed within 72 hours after death with the Maryland ald Hyglene. Id Hyglene. Id other than "natural", or Itema 23a or 28a-f ahow other than "natural", or Itema 23a or 28a-f ahow avant, Ina Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 1 1 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 2 □ Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2☐XNo	Specify:	Puerto F	Rican, etc.)		ck, White,	
2	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)	Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion u <i>ring</i> most	ol workir	ng	16b. Kind of 8	usiness/In	dustry
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	e filed al Hygi other vent, I	Be Co	6 years 17. Father's Name (First, Middle, Last)					(First, Middle,	Maiden Sumai	ne)	
Maryland		ToE	Michael Manning					et Bal			
Mar					ng Address (Street ar						
altimore,			20a. Method of Disposition 20b. Place o	f Dispo	sition (Name of matory or other place			ate	20c. Location		
Ĕ	. Pages tment of tant: If it jury or o		ne leest and a second		ol Crema		12-	-29-09	Dove	er, I	De.
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	0 1	R. Carro	7 7 TT		D	eral H	lome	, PC
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition and the condit	not ent	er the mode of dying	X 51 I, such as c	cardiac o	St. Mi r respiratory and	chaels rest,	3, M	Approximate Interval Between Onset and Death
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760,	ite be executed ysician and ne burial-transit	cai Ex	resulting in death) Last Due to (or as a consequence	of):							
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<u>Ita</u>	Physicien: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?		100		of Death	(Check only o			
0	Physi r this o ral dire	5	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Oi 27. Manner of Death 28a. Date of Injury 28b.	Time o		4 L Nur		ne 5 Resid			rfy)
o	Attending I r death, ector: After by the funer	ation	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work	? ′es 2 □ N			. ,		
Divis	al or Attendes after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, st	reet, factory, office			28f. Location (S City or Tow		ber or Rui	al Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	e, deat	h occurred at the time vestigation, in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	cause(s) and m date and place	anner as	stated. to the cause(s)
	To t Withi To tl	Σ	29b. Signature and title of certifier		29c. License		0 -		29d. Date sign	ed (Month	, Day, Year)
•			2h Hamonhe	/T		02	9 V		124	1200	5
			30. Name and address of berson who completed cause of death (Hem 23a) Eric Hermansen, MD, 316 Rai	1 ~	our bee	Go14	deha	oro M	م م 1 م	36	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 2 9 2009	pa	ales	- 40±(JUGD	, , , , , , , , , , , , , , , , , , , 	2. 210	30	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Day 2009 Physician 11:40 P M /Medical Mary Alice Moyer 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's 9 Birthplace (State or Foreign Country) 1948 Virginia St. Mary's Hospital

5. Social Security Number 6. Sex Leonardtown

Inder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 19, 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 😾 F 218-52-8466 61 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical EXX. item must be rediffied at once. 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7030 Carrico Mill Road 20637 United States by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thurston B. Taylor Elizabeth L. Mitchell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis A. Moyer/Husband 7030 Carrico Mill Rd., Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 Burial 2 □ Cremation 3 □ Removal from State Immanuel methodist cem. 4 ☐ Donation 5 ☐ Other (Specify) Brandywine, MD 7,2010 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Brinsfield-Echols F.H., P.A., M00817 PO Box 128, Charlotte Hall MD 20622 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MIN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner U Sequendary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine 10 ev Hers, or The law requires that the death certificate be execute attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnapt 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) o 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Vital 1 □ Ýes 2 1No or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day,

MARY

parked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. M. Panwala, Charlotte Hall, MD

Year)

JANU 4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 31 Physician/ 2009 5:00 December Virginia McLaren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's 21689 North Essex Drive Lexington Park Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 0570771924 Washington, DC Director 85 213-44-3431 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland St. Mary's Lexington Park 10f. Zip Code 10e, Street and Number ò 10g. Citizen of What Country? Iral", or items 23a or Examiner must be Funeral 20653 USA 21689 North Essex Drive permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify. 3 X Widowed 4 □ Divorced White Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) the County Government 12 Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Pauline F. Headley Roland S. Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Woodland Drive, Byron, Georgia 31008 Marleen McDaniel/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ÷ 5 1 Durial 2 Cremation 3 Removal from State Important: I any injury o Charles Memorial Grd | 01/07/2010 | 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD Supraure Fune 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) emenona Medical Due to (or as a consequence of): Examiner winne Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. **Director:** After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Exam Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: ဂ္ 4 Nursing Home Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: Natural 28d. Describe how injury occurred iniurv 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H005575-1

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DHMH 17 Rev 7/2009

State Registrar 40900 Merchants La., Leonardtown, MD 20650

reas of person who completed cause of death (Item 23a) (Type, Print)

D.O.

Jennifer Schmidt,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death moore Physician/ Month Dacambes Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Community HOSDITA rince Lanhan 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State Foreign 7. Age (In vrs. last birthday **Funeral** (Month Day, 48 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Completed by Funeral Director Charles Waldort Yes 2 No 10g. Citizen of What Country? ROOKShead Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 Hoolf Yes, Give 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 moore Diana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ineta moore 407 Birchleat ave Capital Heights 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Riverdale Park Cyematery 01-04-2016 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licer Ups nur st NW Wash. 23a. Part 1. Enter the disease, bromplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Renal disease **Examiner** Sequentially list conditions, if any tracing terminal cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fer death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Non-ischemic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a, Was an performed Yes 2 2 No 1 Yes 25. Was case referred to proced 26. Place of Death (Check only one) examiner? 2 A No Hospital Other: 1 Tes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier D0060120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 nitchellerille Rd # B216 20716 DEC 3 0 2009 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 18 Ruth Irene Looper Morgan Dec. 8:50 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pineview Nursing Home Prince George's Clinton 9. Birthplace (State or Foreign Country) Georgia 8. Date of Birth (Month, Day, May 26, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. 1 □ M 2 🙀 F 1924 577-52-6371 Yrs. Director 85 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be procedure. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 9909 Lyndia PLace 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2K No Specify: Specify: African 3 X Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) **6th** College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Looper, Sr. <u> Annie Mae Bailey Looper</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tarsica Morgan/Grand Daughter 9909 Lyndia Place Upper Marlboro, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 1 St Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Washington National Suitland, Maryland Stewart Funeral Home, Inc. Signature of Funeral Service 22. Name and Address of Facility 4001 Benning Rd. NE 20019 Washington, DC 23a. Part 1. Exter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscierotic Cardivascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the bunial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗆 No 1 🔲 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 💆 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🗵 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

cr 2

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D45365

December 29, 2009

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 25, 2009 Physician 9:05P М Mehalso Carol Anne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 64 May 29, 1945 Director 186-36-9181 Pennsvlvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exacult variants by retilied at 1 ∐Yes 2 🛣 No Director Temple Hills Maryland Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20748 <u>3334 Huntley Square Dr. Apt. Bl</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Administrative Ass't. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anne Tulenko Mehalso Michael ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Mehalso/Brother 1013 Morewood Rd. Hardy, VA. 24101 20b. Place of Disposition (Name of Kalas Crematory or other place) 20c. Location - City or Town, State Edgewater, MD. 20a. Method of Disposition 12/31/2009 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State √5 □ Other (Specify) 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Par 1. Enter the disea e, or complic for that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metasta Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mo 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December D46741 25, 2009 MD who completed cause of death (Item 23a) (Type, Print) Deepak Sachdeva, M.D. 11711 Livingston Rd. Ft. Washington, MD. 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 3 0 2009** Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 27, 2009 11:30 p_M Helen Louise McPherson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Prince George's Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2🛣 F Months Dec. 3, 1937 Kentucky Director 406-44-8621 72 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Prince George's Temple Hills Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5631 Fisher Road 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's County Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Manager Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Roe Ethe1 Hamby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David McPherson - Husband 5631 Fisher Road, Temple Hills, MD 20748 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2009 Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityGeorge P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enler it is disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ulmonder nronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Exami b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month 4 Pregnant a Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 2 No 3 Probably 4 Unknown iobetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → Yo 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျ 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cep 29c. License number 29d. Date signed (Month. Day Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive G-06 CLINTON Hospital 10403 DEC 3 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** December 24, 2009 McDonald 12:02 A M Robert Myles /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 2, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 219-46-5503 **X** M 2 □ F 62 Months Hours Washington, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ms 23a or 28a-f short 1 ☐ Yes 2XX No Funeral Director Prince George's Maryland Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 USA 15615 Dorset Road #103 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2¥XNo Specify þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Estimator 2 years Mechanical Contractor 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Robert Henry McDonald Mary Margaret Dunleavy ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Margaret LoMedico / Sister 10930 Ward Road Dunkirk, Maryland 20754 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition MX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 12/31/2009 Clinton, Maryland 21. Signature of Fundral Service Lice 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of the art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FATAL **Physician** /Medical Due to (or as a consequence of) Examiner Source Italy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2XNo Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending dea h. 1 ☐Yes 2 ☐ No investigation Director 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier X agunas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL LAGUNAS-FITTA. MD 31. Date filed (Month, E State Registrar

DHMH 17 Rev 1/2001

		For State Registrar		State of	r Marylan		oartment of H e <i>rtificate of L</i>		nentai Hyg R	eg. N2 0	09	43250
Physicia		1. Decedent's Name (First							2. Date of Dea Month 12-23-	th	Year	3. Time of Death 2110 P M
/Medic Examin		4a. Facility Name (If not in PENINSULA				NTER	4b. City, Town, or SALISE	BURY		WIC	nty of Deat	
Funeral Director		5. Social Security Number 578–42–813	8 1[ex □ M 2【 X F	7. Age (In yrs.	last birthda 76 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 2-21-1) 33°	g. Birt WASH	hplace (State or Foreign unity) INGTON, DC
f show	or	Usual Residence of Deceding 10a. State 10b. MAINE	County AROOS	LUUK		ty, Town or						10d. Inside City Limits 1 ☐ Yes 2 🏋 No
a or 28a-	Director	10e. Street and Number				10110 1	10f. Zip Code 04739			0g. Citizen o	f What Co	untry?
penint. Tages I am 2 should be little within 72 hours aren bean with the waryants Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiryar must be multied at once.	by Funeral	2360 AROOS' 11. Marital Status 1 Never Married 2 3 Widowed 4 D	☐ Married		2 X No ve No	.S. 10	3. Was Decedent of Hi If Yes, specify Cubar 1 □Yes 2 ▼No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. R	lack, White	rican Indian, e, etc. VHITE
ian "natural	Completed 1	15. D	ecedent's Edi y highest grad			(Gi life	cedent's Usual Occupa ve kind of work done d . DO NOT use retired	luring most of work)		16b. Kind of		,
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th and Me 7 is mark traumatio	ပ္	19a. Informant's Name/R	elationship (7				iling Address (Street a					
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nysician Medical		23a. Part 1. Enter the dise shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease or comp re. list only o	a. CARD	ach line.	SHOO		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death HOURS
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been signed by the should be detached	ed by Phy	Part II. Other significant				sulting in the	underlying cause give	en in Part I.				o the cause of death? robably 4ሺ Unknown
icate has be , page 2 sho	Completed								24a, Was a autop perfor 1 □Yes	sy med?	prior to death?	utopsy findings available completion of cause of
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be	2 Accident	F	28a. Date (Mon		ER/Outpat 28b. Time Injur	y Work	4 LI Nursing H	ome 5 ☐ Resid	ence 6 Co	curred	
ours after d	l Certifi	4 ☐ Homicide	determined	buildi	ing, etc. (Speci	ify) 	street, factory, office	me, date and place	City or Ton	n, State)		ural Route Number,
within 24 h To the Fun completely	Medical		Aedical Exam	iher: On the b			29c. License	pinion, death occu e number	rred at the time,	date and place 29d. Date sig	e, and due	
TYO		30. Name and address of DR. JAMES					e, Print)					-
Sta Registr		31. Date filed (Month, Da	C 2 9				parker					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar AMEND#20 open FH, 12/30/09, BMW, McCo Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 1800 Oto Mercy Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth 9. Birthplace (State or Foreign Country) Ghana 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 1 /9 4 9 94 2 Months 1 M 2 TF 67 Director 228-19-6724 Usual Residence of Decedent with the Maryland at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified Charles Waldorf MD 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r ō Funeral 20603 9497 Pet Rally Lane USA ral", or items 2 Examiner mus filed within 72 hours after death val Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home the Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 27 is marked or traumatic eve and Mental ၉ Rose Awusi-Dede unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kingsley Opoku/Son 9497 Pet Rally Lane Waldorf, Md. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2010 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cemetery 2/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Awupome Accra, Ghana PHYLTPOPS RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Signatur Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Year Month Dav Pregnant at time of death signed by the a be detached f Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ H1N1 Influenza 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2X No 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗷 No 1 Tes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 \square Pending 1 🗌 Yes 2 🗌 No 24 hours after death. Funeral Director: A М Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the ! Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ρ Dec.21,2009 H64588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd.Silver Spring, Md 20910 Ashish Tol 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #20a, 1- For FH, TCHD, pha Amended, #20a, 1- Registrar #20b, #20c, TCHD, 12/29/09, TLS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** John Henry Outland Jr. Dec 15 2009 4:45 PM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 218-48-8431 Director 61 10-11-1948 DE Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, its Modice Examinar must by portified at 1XYes 2 □ No Director MD Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 205 Market Street 21629 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married "natural", or Maryland 21215-0036 1 □Yes 2 No Specify Specify: Black þ 3 Widowed 4 Divorced Outland Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Riverview Manor Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other than any Injury or other transmission. Apartments 11th Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Lee Spruill John Henry Outland Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 403 Denton, MD. 21629 Diana Little/Sister Baltimore, Sob Place of Disposition (Name of Disposition Charles of Disposition (Name of Disposition Charles of Disposition (Name of Disposition Charles of Disposition (Name of Disposition) (Name of Dispositio Discount of Discounting (Name of Discounting of Discounting of Otto Polace LLC 12/294) 2009 20a. Method of Disposition 1 Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home Signature of Fune al Service Licensee 426 E. Dover St., Easton, MD. 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on exch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Talle Myolardial MINUTES disease or condition resulting in death) /Medical Due to (or as a conse mence of): Examiner wans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to was a consequence of) lears and burialattending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No P.0. 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending death. n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 3 🗌 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

State Registrar

DEC 21 2009 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

610

32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ROWLEY

ASTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year PALACIOS BABY 6:45 PM GIRL 12 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Year 1 □ M 2 🔽 F None Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 ☐ No Montgomery Silver Spring 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 705 Langley Drive 20901 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 24 If Yes, Give Year or Dates: Specify:White SpecifyEl Salvadoran 1 XYes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jose Mejia Antonia Palacios 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonia Palacios / Mother 705 Langley Drive Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 12-29-09 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee WU 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe CONCE Due to (or as a consequence of) Sequentially list conditions, if any, heading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Line to for es a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2□No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Director

Completed by Funeral

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amp injury or other traumatic event, If a Medical Examinat must be notified an once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

burial-tran as the

Examiner

Physician/Medical

Be Completed

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed and physician this certificate has been signed by the attending al director, page 2 should be detached for use as within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, "

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Prematurity

25. Was case referred to medical examiner? Hospital: 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 ☐ Yes

26. Place of Death (Check only one)

2 **X**No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

27. Manner of Death

2 Accident

3 Suicide

4 ☐ Homicide

1 Natural

29c. License number D66134

29d. Date signed (Month, Day, Year) 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRYSANTHE GAITATZES MD 1500 FOREST GLEN RD. SILVER SPRING ND 20910

State Registrar 31. Date filed (Month, Day, Year) DEC 30



within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 19 State Registrar FH Certificate of Death TCHD, 12/22/09, rs 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decembe Physician/ 2009 2326 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospita Easton albot If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
JUNE 22,1939 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F WASHINGTON, DC Director Yrs. 578-50-9601 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1x Yes 2 ☐ No MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral -28787- dustin avenue 21601 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MASONRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LAWRENCE R. PAYNE RUTH ZELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN PAYNE/WIFE <u> 29787 DUSTIN AVE., EASTON. MD</u> 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OXFORD CEMETERY DEC.23,2009 OXFORD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST. 2 mf RCEROS EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Aneur Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury (or as a consequence on ibrillation CRVS the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No 2 1 filled in by the funeral director, To Be 25. Was case referred to predica 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esten Lane RS 6 31. Date filed (Mont State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, 2009 **Physician** Archie Lee Peterson 0009 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner George's
irthplace (State or Foreign 9910 Moreland Street Washington Prince 8. Date of Birth (Month, Day, h 9. Birthplace (State Country) , 1934 Virginia Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 224 40 7640 75 Nov. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits of Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Madical Examinar must be notified at Director 1 ☐Yes 2 ☐ No MD Prince George's Fort Washington 10e. Street and Number 10g. Citizen of What Country? 9910 Moreland Street 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yఈ, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 7/57 8/57 1 □Yes 2 🛛 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Driver Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f es 1 and 2 should be of Health and Ments litem 27 is marked rother traumatic er ပ Emmett Peterson Lavesta Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2074419a. Informant's Name/Relationship (Type. Print) Rose G. Peterson/wife 9910 Moreland Street Fort Washington, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem 12-29-09 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signatule of Funeral Service Licensee nputaker 2294 Old Washington Rd, Waldorf, MD. 20601 M1595 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Diabetes Mellitus Type II and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐Yes 2 ☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69552 December 28, 2009 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Claudiu Austin,MD.

DEC

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7700 Old Branch Avenue #D203 Clinton, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 27 2009 10:30 A M December Rebekah Ann Parks /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LATA HARLES IVISTA MEDICAL ENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Feb. 4, 1928 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2¬F Washington DC Yrs Director 34 9246 578 Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumetic event, the Myclical Evans had out be notified at 1. Yes 2 No Director MD Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14517 Bittersweet Drive Funeral death 20637 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married þ 1 ☐Yes 2 ☐No 3 ₩idowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 10th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental 1 and 2 should be ပ George Arthur Boteler Elizabeth Mabel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin M. Hooper/daughter 14517 Bittersweet Drive Hughesville, MD20637 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Washington Nat' l ¢em 12-30-09 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signature of Funeral Service Licensee 2294 Old Washington Rd Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cordiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Year Month Day 5 Other (specify) the signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: certificate 1 □ Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical one. within 2 29d. Date signed (Month, Day, Year 29b. Signature and e of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address

31. Date filed (Month, Day,

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2009

Year)

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person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State	State of	Marylan	•	rtment of H		Mental Hyg	giene Reg. No 2009	43257
			Registrar 1. Decedent's Name (First, Middle	(ast)			inicate or i	-	2. Date of Dea		3. Time of Death
	Physicia	an	•						December 1		
•	/Medic		Betty W. Patri 4a. Facility Name (If not institution		ther)		4b. City, Town, or	Location of Deat		4c. County of De	
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7			Usual Residence of Decedent						, , , , , ,		
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5 4	Ment Ment arked artic e	70	Edward Wilki	.e					Lillian l	Doris Owen	S
Cally I all Call Cally 20030	aum saum saum saum saum saum saum saum s		19a. Informant's Name/Relationsh							er, City or Town, State	
9 Pue	m 27	. 25	Kathleen Dento	n (Daught	· · · · · · · · · · · · · · · · · · ·					Plains, M	
Pages 1	if ite		20a. Method of Disposition 1 X Durial 2 Cremation	3 Removal from S	State 20b. P	lace of Dispo: emetery, cren	sition (Name of natory or other plac	_{e)} Jan 6	,Da 2 010	20c. Location - City of	or Town, State
, d	tant: jury		4 ☐ Donation 5 ☐ Other (Sp	pecify)			d Vetera		ery	Cheltenha	m, Maryland
	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprinter must be refitted at once.		21. Signature of Funeral Service I				. Name and Addre	-			Inc 6633 01d
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	Medical xaminer		rodaling in doding	Due to (c	or as a consequ	uence of):					
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te be	physicia the bur	dical		d							
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5 E	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pregnanc	v		23d. Date of o	•
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gi G	h. Afte fune	ertification:	1 Natural 5 Pending 2 Accident investig	g (Montl	h, Day, Year)	Injury	Wor	k? Yes 2 □ No	Eodi Boombo i	non injury coccined	
Affer	dear ctor	fica	3 Suicide 6 Could r		of Injury - At ho	me, farm, str	eet, factory, office			Street and Number or	Rural Route Number,
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the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	edical	(Check only 2 Medical one)	Examiner: On the ba and mann		uon ang/or in	vestigation, in my o	ppinion, death occ		date and place, and d	
Tot	with To t	Ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
			1/1/01/				09	15365		12-24	-(00)
£	\$10		30. Name and address of person	idanons	m. 1	23a) (Type,	Print)	for N)	# 6/f+	Use you	-2005 MA 2078
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	egiotrar's Signa	ture -					

DHMH 17 Rev 1/2001

			1 - For State Registrar	of Maryland / Do	epartment of Certificate o			ene . No 2009	43258
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MICHAEL THOMAS FRITZ	PISTOR			2. Date of Death Month DEC 24,	Day Year 2009	3. Time of Death 0832h M
-	Examin		4a. Facility Name (If not institution, give street and			, or Location of Death		4c. County of Death	
- stem	The end of the control of the contro		4940 Sentinel Drive		Bethes			Montgomer	J
	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □	7. Age (In yrs. last birth	day) If Under 1 Years. Months Day		8. Date of Birth (Month, Day, Y APR 29	(ear) 9. Birthp Coun 1930 Oreg	
	w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			11	0d. Inside City Limits
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	the 1 28a- notif	Directo	10e. Street and Number	Decires	10f. Zip Code		100	. Citizen of What Coun	try?
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N	iled v Hygie ther t nt, th		17. Father's Name (First, Middle, Last)	0.5	• Allibassau		w 1. e (First, Middle, Ma	uiden Surname)	
yland	d be funtal he	Be	William	p-	istor	Virginia	•	iden Garname)	Pollard
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene in the 78a-if show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	은	19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip	
Z Z	nd 2 sulth ar 27 is r trau		Julia Pistor / Daught		,			geles, CA	*
ē,	s 1 and 5 f Health Item 27 other tr		20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other p			c. Location - City or To	
Ê	Page lent o nt: If ry or		1 ☐ Burial 2 【ACremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)		ic Cremato		/2009 G	len Burnie,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	— моо956	22 Name and Add Thibadea 7 Park	dress of Facility au Mortuary Avenue, Gai	Service	, p.a. g, MD 20877	7
10	- 27		23a. Part . Enter the disease, or complications the shock, or heart failure. List only one cause						Approximate Interval Between
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/00/	ate be executed hysician and the burial-transit	Ě	Due	to (or as a consequence of):				
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	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23c If yes	outcome pf pregnancy				20d Date of deliver	
X Q Q	atten for u	cian	in the past 12 months?	ve birth 2 Fetal death	3 ☐Ectopic pregna 5 ☐ Other (specify)			23d. Date of delive Month	Day Year
j.	the d y the ched	ıysi		nknown	o El o inci (opcony)				
T	that hed b deta		Part II. Other significant conditions contributing	o death but not resulting in t	the underlying cause	given in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
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ecord	law re as bee 2 sho	Completed					24a. Was an	24b. Were auto	psy findings available
r	o T o	mo					autopsy perform 1⊟ Yes 2	ed? death?	inpletion of cause of
VITAI	ilcian: Th certificate ector, pag	Be C	25. Was case referred to medical			26. Place of Deat	h (Check only one)	2,140	20110
	Physician: r this certific ral director,	0	examiner? 1 No Hospital:	☐ Inpatient 2☐ ER/Outp	patient 3 DOA	Other: 4 Nursing Ho	me 52 Residen	ce 6 ☐Other (Specif	γ)
ם ר	ding Phystcian: 1. After this certific funeral director,	n: T		ate of Injury 28b. Tin	me of 28c. In	njury at Vork?	28d. Describe how		
Vision	endir ath. or: Af	atio	2 Accident investigation			☐Yes 2☐No			
<u> </u>	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	ace of injury - At home, farnuilding, etc. (Specify)	n, street, factory, offic	oe .	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
_	oital ours af		GOO CONTES AT CONTEST OF Physical Providence To	Abordon abordon de la companya de la	d				
	Hosp 24 ho Fund etely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To Medical Examiner: On the and A	admissis of examination and	or investigation in m	v opinion, death occur	red at the time dat	a and place, and due to	the cause(s)
	omple	Me	29b. Signature and title of certifier		29c. Lice	ense number	290	d. Date signed (Month,	Day, Year)
1	TE O		De maria	/ ~ DM	10	00418	(Dec. 28 3	2009
	4+1		30. Name and address of person who completed	cause of death (Item 23a) (T	ype, Print) 2101	surfice	2 Park	D,	
			29b. Signature and title of certifier 30. Name and address of person who completed of the complete of the com	MODME	5,10	er Spra	-7 mn	20900)
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature			/		
	Registr	ar	DEC 29 2009 2	when B. Apr	artes.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43259 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 December 1335 Mildred Stern Goldstein Pearlman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Hours 02/06/1916 Director 288-22-5869 93 Ohio Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6105 Montrose Road, Apt. #2190B 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0. 1 Never Married 2 Married Completed by 1 Yes : 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", White 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Tifereth Israel Cong. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Stern Anna Rucsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Dale Pearlman - Stepdaughter 18249 Rolling Meadow Way, Olney, Maryland 20832 Important; If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Gdns. 12/27/2009 Olney. Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. M00207 MD 20904 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and for use as the burial-transit Cardiac Arrest that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Chronic Obstructive Pulmonary Disease IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna
☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death 9 Unknown 9 Unknown Ö þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Huponatremia Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure 24a. Was an autopsy Yes 2 X No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 A Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours aft To the Funeral Di completed filled in Medical 29a, Certifi 1. 📉 Certifying Physidian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Muse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29d. Date signed (Month, Day, Year) 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 8600 Old Georgetown Road, Bethesda, MD 20814 Sima Nourani Zenuz,

State

Registrar

31. Date filed (Month, Day, Year)

DEC 29

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 33:00A M thur Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital Montgomery Social Security Number 8. Date of Birth 1942 (Month, Day, Year) September 11, If Under 1 Year I If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State Natreign **Funeral** 1 🛣 M 2 🗆 F Days Hours Westmoreland Ct 227-58-5892 Director 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2717 Hartford Street SE 20020 United States 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc." δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) **Twelth** College (1-4 or 5+) None Private Wireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Raymond Roy Sr Julia Roy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 Hartford St SE, Washington DC 20020 Sarita Hayes Roy/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 12, 1 ■ Burial 2 Cremation 3 ■ Removal from State 4 Donation 5 Other (Specify) Quantico National 2010 Triangle, Virginia 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service Scensee Donald R. Gray 661 Good Hope Rd SE, Washington DC 20020 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or shock, or heart failure. List Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** eumohl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a d be detached f P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.

Director: After this d in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 BLUD Sast University 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) ח ח Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ²25, 2009 Mary Jean Reed December 10:30A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's 8326 26th Place Adelphi 8. Date of Birth Apr. 20, 1933 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 □ M 2 🗓 F Pennsylvania 210-24-5660 76 Vrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Prince George's Maryland Adelphi 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8326 26th Place 20783 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 □ Yes 2 🖾 No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Scarcia Maria Paoletti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald J. Reed -Husband 8326 26th Place Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20c. State 20c. Location - City or Town, State 20c. State 20c. Location - City or Town, State 20c 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fineral Service Lice see Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Con estive Heart Failure 10 years Due to (or as a consequence of): Aortic Stenosis 5 years Sequentially list conditions, if any, leading to interest active cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or sels, consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 24 No Month Day Year 5 ☐ Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a. Was an 1 □ Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 1≦ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760 attending physician for use as the buria signed by the a Division of Vital Records, page 2 s director, funeral After Hospital or Attending ours after death.

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f sho

within 72 hours after

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If Maric 2008.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical 2 Completed Be Certification: To

Medical

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

and manner stated

29c. License number D26287

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

December 28, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Berard, MD 7305 Baltimore Avenue, #107 College Park, Maryland 20740 31. Date filed (Month, Day, Year)

State Registrar

24 hours a Funeral L

To the within 2

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:20 AM DECEMBER 28 2009 CHARLES ELLIOTT RISLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days **MARYLAND** Director 217-14-8748 89 JUNE 9, 1920 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director GRASONVILLE MARYLAND QUEEN ANNE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21638 115 PERRY CORNER ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Follows:
1 Fyes 2 □ No
If Fes, Give
Year or Dates: 1941–1945 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **GOVERNMENT** FIELD SUPERVISOR/DELEGATE Pages 1 and 2 should be filed inent of Heelth and Mental Hygic Int: If Itam 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATIE PARKS FREDERICK R. RISLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARGARET M. RISLEY/WIFE 115 PERRY CORNER ROAD, GRASONVILLE, MARYLAND 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JANUARY 2 permit. Pages Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 2010 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ ★ o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3 No 3□ DOA Certification; To 2 ER/Outpatient 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 12/18/2079 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) 2108 D. Doot Drin Chester MD 2/6/5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

		,	for State Registrar	State of Marylar	•	artment of I rtificate of			giene Reg. No. 2009	43263
	Dhuaist		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath Day Year	3. Time of Death
	Physicia /Medic		OLIVIA F		R	CZZ		DECEMB		29 8:40 PM
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Dea	th	4c. County of Dea	
			5. Social Security Number 6. S			L A PL	If Under 24 Hrs	s. 8. Date of Birt	CHAR	rthplace (State or Foreign
	Funeral Director		1	□M 2□F	Yrs.	Months Days		. (Month, Da	y, $Year$) C	ountry)
			225 22 9052 Usual Residence of Decedent	x 85				April	9,1924 Vi	rginia
	how	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	e Ma Ba-f s	cto	MD Charle	es Be	el Alt	on				1 □ Yes 2 □ No
	or 2	ä	10e. Street and Number 8755 Fairgrou	nd Dood		10f. Zip Code 206	11		10g. Citizen of What C US	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Madical Examinar must be notified at	Funeral Director			10			0 " 1		
	item	E.	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2□No	I.S. 13. V	rvas Decedent of I f Yes, specify Cub	pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
2000	urs af	δ	3☐Widowed 4☐Divorced	If Yes, Give X Year or Dates:	1	I□Yes 2□No	Specify:		Specify: P	lack
ה ה	2 hor	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	dent's Usual Occu	pation	adda a	16b. Kind of Business	/Industry
7	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wo		G	L
7	ed wi		12th		Admi	nistrat			Governme	nt
5	ould be filed within Mental Hygiene. arked other than atic event, the Matic event.	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Š	should I and Men s marke umatic	욘	Robert Foreman 19a. Informant's Name/Relationship (40h M-00-	A status /Otro	·	sie Hol	Loway er, City or Town, State,	7'- 0-4-)
2	d 2 sho th and 7 is ma trauma		Lidia Guzman/da			,			er, City or Town, State, NC 2850	. /
บั	s 1 and 2 should be filed within 72 hours after death with the Maryian of Heath and Mental hygiene. If then 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Examiner must be rediffed at		20a. Method of Disposition			sition (Name of natory or other pla		Date	20c. Location - City or	
2	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removal from State			i	4 2010	mada sa ala	Winainia
al III	permit. Pages 1 and Department of Heal Important; If item 2 any injury or other once.		21. Signature/of Funeral Service Ligen	. 20	22	. Name and Addre	ess of Facility RT	-4-2010 RTSCOE-'	Triangle	, Virginia ERAL HOME
ŏ	Depa Impo any ir		* KIMIDELLUCIAL	excoe-long.	ann					rf, MD20601
			23a. Par 1. Enter the dis se, or com sh ck, or heart fail e. List only	plications that caused the deaf	-					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Chane	~ C.	ARR				Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		1 - (- 1	- 11			
	Examiner	L	Sequentially list conditions,	b. HYPERTI		<u>بر</u>				+4 Years
	ted sit	nine	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						
, in	execu and al-trar	Examiner	that initiated events resulting in death) Last	c. Dem Eng Due to (or as a consec						AT YEARS
	ficate be executed physician and s the burial-transit	dical		d						
	rtificat ng phy as the			, u					- 10	
5	leath certiff attending for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnan			23d. Date of de	elivery
	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of		Other (specify) _	Су		Month	Day Year
Ĺ	res that the de signed by the a be detached f	Phy	9 Unknown					OO- Dida		the course of death 2
Ď	Attending Physician: The law requires that the death certif refeath. refeath. setor: After this certificate has been signed by the attending ector: After this certificate has been signed by the aftered for use as by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	ideriying cause gi	ven in Part I.	23e. Did to	obacco use contribute t ′es 2 .≪ No 3.⊟ F	Probably 4 Unknown
5	w requir s been s should	Completed								
ב ב	ne law e has ge 2 s	du						24a. Was autop	an 24b. Were a esy prior to rmed? death?	utopsy findings available completion of cause of
<u> </u>	n: Th	မ င်	25. Was case referred to medical					1 □ Yes	2 X No 1 □ Ye	s 2 🗆 No
>	/sicia s cert lirecte	o Be	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital: 1 ☐ Inpatient 2 🛣	FR/Outpatien	t 3 DOA Oth	or:	eath (Check only o	<i>ne)</i> lence 6 □Other (Sp.	- 16.0
5	ding Physician: The In. After this certificate ha funeral director, page	H :	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	ry at		now injury occurred	эспу)
5	ath. rr: Aff	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	M 1 🗆	rk?]Yes 2 □ No			
2	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (S	Street and Number or F	Rural Route Number,
2	ital o									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exan	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	n occurred at the t vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
	Fo the vithin of the complex c	Med	29b. Signature and title of certifier	and mainer stated.		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	F>F0	_	130	- CRN	. 20	18 7	4887		12/26/	1
7			30. Name and address of person who		-		3001		1-126/	2009
62	5		PAUL M. PAS	C102937	1151	A LAG	2 ANGE	AVE, +	\$101 KA	ginso mo.
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature /	arked		,	,	
	Registra	ar	540 252	La contraction of the contractio	1. 14					

OTHAMINO!

	_	State of Maryland / Department of Health a 1 - State Registrar Certificate of Death	and Ment		ene g. No. 200	9 43264
Physiciar		Decedent's Name (First, Middle, Last)		ate of Death		3. Time of Death
/Medica		Adele Rubin	Dec		23, 200	9 5:20 P M
Examine	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			4c. County of E	
Funeral		Brighton Gardens of Tuckerman Lane North Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24 Hrs. R Da	ate of Birth	Montgom	Birthplace (State or Foreign
Director		102-09-2612 1 M 2X F 101 Yrs. Months Days Hours	Min. (M 09	fonth, Day, \\\ \/ 01/1	908 P	oland
and	- 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d, Inside City Limits
Mary In Sho	5	MD Montgomery North Bethesda				1 X Yes 2 □ No
or 28g		MD Montgomery North Bethesda 10e. Street and Number 10f. Zip Code		100	g. Citizen of What	t Country?
ath wi	<u>a</u>	5550 Tuckerman Lane 20852			USA	
S 8 8 9 1	Dy ru	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 1 ☐ Yes 2 ☑ No Specify:	gin? (Specify Ye , Puerto Rican,	es or No- etc.)	Black, W Specify:	American Indian, Thite, etc. White
5-0 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most	of working	16	Sb. Kind of Busine	
121 vithin ane. than "		Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				
d 2 filed v Hygic out, in	3	12 Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother			Manufact Liden Surname)	uring
lan lid be fental ked o	90 01		n Dingo	,	,	
ary shou and N s mar		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number			City or Town, Sta	te, Zip Code)
and 2 ealth m 27 in rer tra		Lawrence E. Rubin/ Nephew 11205 Hurdle Hill D	or. Pot			
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 21 ☐ Value an Memorial Gardens 1.	Date 2/28/20		oc. Location - City	or Town, State
Balt permit Depar Import any in		21. Signature of Funeral Service Licensee M01477 22. Name and Address of Facility Danzansky-Goldbe 1170 Rockville	erg Mem Pike Ro	ockvil	le, MD 2	Inc. 20852
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multi Organ Failure	cardiac or resp	iratory arres	st,	Approximate Interval Between Onset and Death
Examiner	<u> </u>	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): b. Atherosclerotic Heart Disease Due to (or as a consequence of): c.				Years
icate be executed physician and it the burial-transit direct Evaminer	1	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
e death certification of the attending led for use as	1 yalcıdı i i ililinedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
cords, P.(w requires that the been signed by the should be detact	i i	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoperosis	23			e to the cause of death? Probably 4 🗀 Unknown
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be on the completed by	and I		_	4a. Was an autopsy performe □Yes 2	24b. Were prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
Vita		examiner?	of Death (Chec			Assisted
Vision of Vita Attending Physician: rebath. ector: After this certific by the funeral director, filcation: To Be C		27. Manner of Death 1 ☐ Inpatient 2 ☐ EH/Outpatient 3 ☐ DOA 4 ☐ Nurs 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. D		ce 6 X Other (:	Assisted Specify/Living
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To		2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Lo	cation (Stre ty or Town,	et and Number o State)	r Rural Route Number,
o the Hospita ithin 24 hours o the Funera ompletely fille		29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and du th occurred at t	ue to the cau he time, date	use(s) and manne e and place, and	er as stated. due to the cause(s)
To the within committee of the transfer of the		29b. Signature and title of certifier 29c. License number D 1 960	9.		d. Date signed (M	
	;	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1.0	- 0 (1
		Raman Tuli, M.D. 10810 Darnestown Rd, Ste. 202 Ga	ithersb	urg,	MD 20878	
State Registrar		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43265 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 4:45p M 2009 Rego Teresa Medical 4a. Facility Name (if not institution, give street and number) 4c, County of Death **Examiner** 4b. City. Town, or Location of Death Sanctuary at Holy Cross Montgomery Burtonsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funerai Months Days Hours Min 08/28/1937 Director 219-29-9332 Bangladesh Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e Street and Number 10f, Zip Code ò 10g, Citizen of What Country? Funeral items 23a 3 Castle Cliff Court 20904 Bangladesh 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 'natural", or ģ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Asian Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & Daniel Rozario traumatic Emilia Gomes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominic Rego - Son Silver Spring, Maryland 20904 Castle Cliff Court. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/02/2010 | Silver Spring, MD 4 Donation 5 D Other (Specify) 06 Heaven Cem. 21. Signature of Fun 15 vice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 2100707 <u>11800 New Hampshire Ave., Silver Sprina, MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ þ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the a 1 ☐ Yes ∠ ↓
g ☐ Unknown g [] Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No Yes 2 🔀 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNO 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗍 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Hospital Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the F 29b. Signature and title of certifier 29c. License number 00052566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

9801 Georgia Avnu # 1-17

Bhogavilli,

29

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of M	iaryland /	Depa <i>Cei</i>	artmen <i>tificat</i> e	t of H	ealth a Death	ınd M	lental Hyg	giene ()	09	43266
V.	Dhuciai		1. Decedent's Name (First, Middle, La								2. Date of Dea		Year	3. Time of Death
	Physici /Medic		Glenda D. Ro								Dec. 2	24, 20		4:30p ^M
	Examir	ier	4a. Facility Name (If not institution, giv 6407 98th Ave		·)		4b. City, Lan		Location o	f Death		4c. Coun	ty of Death	
	Funeral		Social Security Number 6. S		ge (In yrs. last b	irthday)	If Under	1 Year	If Under 2		8. Date of Birt	h	9 Rirthi	place (State or Foreign
ь	Director			□ M 3€ F	56	Yrs.	Months	Days	Hours	Min.	April	18,53	Mar	yland
	pu		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	am or Lo	nation							10d. Inside City Limits
	Maryli f•ho	ō	Md. P.G.		Lanh		cation							1√2 Yes 2 □ No
	the f	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	th with		6407 98th Av	е.				2070	06			U.S.	Α.	
	d within 72 hours after death with the Maryland jiene r than "natural", or llems 23a or 28a-f ehow the Medical Examinar must be routiled at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. \	Vas Deced	lent of His	spanic Orig	in? (Spe	ocity Yes or No- Rican, etc.)	14. Ra	ice - Ameri ack, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ₹ If Yes, Give Year or Dates:	No		I ☐ Yes						ify: Bla	
9	2 hou		15. Decedent's E	ducation		a. Deced	lent's Usua	al Occupa	ition			16b. Kind of		
215	thin 7.	ple	(Specify only highest gra Elementary/Secondary (0-12)	ide completed) College (1-4or	5+)	life. L	kind of woi	se retired)		of worki	ng			•
21	7 6	Completed		11		S	ales	т-					iranc	e
Maryland 21215-0036	e de la	Be	17. Father's Name (First, Middle, Last, Warren Wash	ington							(First, Middle,		ıme)	
Ž	should be nd Mental marked c	P	19a. Informant's Name/Relationship (19	h Mailin	a Address	(Street a			S Cou		State Zir	Codel
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Lori L. Roger											Md20613
Jre,	ss 1 as of Head Item		20a. Method of Disposition		20b. Place	of Dispo		ne of	1		ate	20c. Location		
imo	Pages nent of I ant: if It ury or o		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Wash	ing	tonN	atio	őna¦l	jar	12,09	Suit	and,	Md.
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licer	nsee	h-	22 R	Name an obin	d Address	s of Facility Fund	eral	Was Home	hingto 1313	n, D 6th	.C.20001 St.NW
	Ø.		23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. Do	not ente	er the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
10.0	Physician		Immediate Cause (Final disease or condition	Athero	sclero	tic	Car	dio	vasci	ular	Hear	t Dise	ease	Onset and Death
43	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):								
€ ' ₂	1880 L	er	Sequentially list conditions if any, leading to immediate	b. Due to (or as	s a consequence	of):								
	d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
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8760,	ate the	edical		d									-	
9	death certific e attending pl id for use as t	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy									
Вох	atten atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal death		Ectopic pro						ate of deliv Ionth	ery Day Year
o.	that the de led by the a detached t	hysl	1 □ Yes 2 □ No 9 ☑ Unknown	9□Unknown				,/,						
rds, P	Se 25 eq	þ	Part II. Other significant conditions of	ontributing to death	but not resulting	in the ur	nderlying ca	ause give	n in Part I.			obacco use co 'es 2 🗆 No	ntribute to t	he cause of death?
900	e taw requir. has been si je 2 should I	Completed									24a. Was		. Were auto	ppsy findings available
œ	The ate h page	Com									autop perfor 1 🗌 Yes	med?	death?	mpletion of cause of 2 No
/ita	i cian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					-		of Death	(Check only o			
of \	shys this al di	T.	1 🗗 Yes 2 🗌 No 27. Man → r of Death	Hospital:			7.0	and the same	4		ne 5 inesid			(y)
O	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		Time of Injury	M	8c. Injury Work 1 □ Y	at ? ′es 2.⊟N		28d. Describe h	low injury occi	irrea	
Division of Vital Records,	I or Attending after death. Director: After In by the fune	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of In	ijury - At home, f tc. (Specify)	arm, stre					28f. Location (S City or Tow		nber or Rur	al Route Number,
	To the Hoepital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeri	edical C	29a. Certifier 1 Cartifying Ph (Check only one) 2 Madical Exam	ysician: To the besi ninar: On the basis of and manner s	of examination a	je, death nd/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) and n	nanner as s	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		4		29c	License	number			29d. Date sign	ed (Month,	Day, Year)
			Salvadas	plos	tera	>		HO	055	92	7	Dece	nbe	29 2009
	4		30. Name and address of person who	co leted cause of	death (Item 23a)	(Type, I	Print)	1 7	Prine	. (7 Leve	2/1	MA	of and
v	Sta	te	31. Date (lied (Month, Day, Year)	32. Regist	rar's Signature	102/	/ /	1	7			11	/	1 0000
	Registr	ar	ALCOU LUUS	neva 18.	park									

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar CHARLE

32. Registrar Signat

31. Date filed (Month, Day, Year) **DEC 3** 0 2009

			For State Registrar	State of Mar			ent of H		and M		ene g. No2	009	43268
	Physicia Medic		1. Decedent's Name (First, Middle, L Sara T. R	ast) uffin						2. Date of Death Month Decembe		, 200 <u>9</u>	3. Time of Death 12:30pM
بر	Examin		4a. Facility Name (if not institution, g	Rd. #225		La	y, Town, or I andove	r			1	unty of Death	
	Funeral Director		5. Social Security Number UNKNOW Usual Residence of Decedent	Sex 7. Age (I	n yrs. last birthda 82 Yrs	Month	ler 1 Year B Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 1ay 13,	1927	9. Birthp Coun Augu	olace (State or Foreign try). Sta, Ga.
	Aaryland 8a-f show tified at	rector	10a. State 10b. County	Georges	0c. City, Town or Landov							1	0d. Inside City Limits 1 🌁 Yes 2 □ No
	vith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 1000 Brightseat	Rd.		10f. 2	Zip Code 20785		-	1		of What Cour	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces?	er in U.S.				in? (Spec , Puerto R	ify Yes or No- lican, etc.)		Race - Americ Black, White, ecify: B1a	etc.
Baltimore, Maryland 21215-0036	ithin 72 houl ene. r than " natu the Medical	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 1 2		(Gi	ecedent's Usive kind of w e. DO NOT u braria	,	tion uring most	of workin	g		of Business Ind	dustry
/land 2	d be filed w Mental Hygi arked othe atic event, i	To Be	17. Father's Name (First, Middle, Las Thomas Ruffin	 		DIGIL		18. Mothe		(First, Middle, M			
Man	d 2 shoul alth and I n 27 is ma er trauma		19a. Informant's Name/Relationship Carolyn William	1 21 -						Route Number,	City or Tow	n, State, Zip (Code)
more	Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	20b. Place of Discemetery, of Riverd	crematory of	r other place					ion - City or Torrale,	•
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Lic	Sure 1 MO	1885	22. Name 553	and Address xander 8 Mar	of Eacility Lboro	Pope Pik	P.A.	stvi	lle, Mo	1. 20747
F	hysician/	6 (7 - 6	23a. Part 1. Enter the disease, or construction shock, or heart failure. List only Immediate Cause (Final disease or condition	omplications that caused the yone cause on each line.	ne death. Do not	enter the mo	ode of dying	, such as o	cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
ر	Medical Examiner	L	resulting in death) Sequentially list conditions,	Due to (or as a c	consequence of):	Her	ivt	for	lure	<u> </u>			
ծ	and transit	Examiner	ir any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Hyper	consequence of:	ų. (11/1	1600	cul	or te	feat	e	
092	ath certificate be executed attending physician and for use as the burial-transit	dical	resulting in deathy Last	Due to for as a c	Insulu	i D	irhet	٠,	me	llifu	<u> </u>		
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3	c pregnancy (specify)	/			23d	I. Date of deliv Month	ery Day Year
ls, P.O.	uires that th n signed by ild be detad	ğ	Part II. Other significant condition	s contributing to death but	not resulting in the	ne underlyin	g cause give	en in Part I			es 2	/	ne cause of death?
Division of Vital Records,	The law req ate has bee page 2 shoi	Completed								24a. Was ar autops perform 1 \(\sum \text{Yes}\) 2	y ned?		psy findings available mpletion of cause of 3. No
ta	cian; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ce of Deat					
Ž	Physi this c	2	1XXYes 2 ☐ No 27. Manner of Death	1 Inpatien 28a. Date of injury	t 2 ER/Outpa		DOA Dirie	4 ∐ Nu		ne 5 🔀 Reside 8d. Describe ho			/)
0 0	nding th. : After : fune	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, Day, 1			work?			ou. Describe no	w mjary oc	Joan Ga	
Divisio	tal or Atter rs after dea al Director ed in by the	al Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be		street, fact	ory, office		2	28f. Location (Str City or Town		umber or Rura	l Route Number,
	he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 Medical Ex	hysician: To the best of maminer: On the basis of exa lurse Practioner: To the be	mination and/or in	vestigation,	in my opinio	n, death oc	curred at 1	the time, date an	d place, and	d due to the ca	use(s) and manner stated.
	Vith with Com		29b. Signature and title of certifier	-a h	N	2	9c. License	number	5-	2	9d. Date si	igned (Month,	Day, Year)
	1		30. Name and address of person wi	no completed cause of dea	th (Item 23a) (Typ					Upper			d. 20772
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's		bare							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene 1- State WCHD/SH 1/6/10 per Dr. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:23 pm Susan Kave SEALS December 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown 11 South Walnut Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 21, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕃 F 219-44-4185 63 1946 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1X Yes 2 No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21740 11 South Walnut Street No. 108 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Maryland 21215-0036 1 ∐Yes 2 No Specify. þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) office manager insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christine Eudora Clopper Donald Alonza Shoemaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11700 Mockingbird Lane, Hagerstown, Maryland 21742 John Quinn - son altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pleasant Hill Cemetery January 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Monrovia, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Fred 415 East Wilson Blvd., Hagerstown, Maryland 21740 Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseq afice of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Due to (or as a consequence of): $UK \ \mathcal{US} \ / \ \mathcal{S}_{\mathcal{C}} \ \mathcal{M} \ \mathcal{E}_{\mathcal{C}}$ Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 05 2 No 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case examiner? Be erred to medical 26. Place of Death (Check only one) FOULA 1 XYes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examine and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000056826

State Registrar

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Posel

nd address of person who completed cause of death (Item 23a) (Type, Print)

ZINCK

William F. Beden

31. Date filed (Mont)

LIND

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#26+30perMD, 12/30/09, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sylvia Grantelin Saunders 2009 December Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Kensington Park Retirement Community Kensington Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav) Funeral Days (Month, Day, Year, 1 🗆 M 2 👿 F Washington DC Director 579-34-1211 Iune Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 1 XYes 2 No Kensington MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Funeral with 23a United States 20895 3616 Littledale Road items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by ö 1 Yes 2 No 1 ☐ Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Specify: Black Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Vermal Mae King Augustus C. Saunders, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print)
Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington.DC 20011 Webster Street. North West Augustus C. 20a. Method of Disposition Saunders, Jr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State any injury or 12/22/2009 Suitland, Maryland Lincoln Cemetery 4 Donation 5 Other (Specify) 21. Sign wre of Funeral Service Lightsen 22. Name and Address of Facility McGuire Funeral Service, Inc. RIO 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final <u>Years</u> Physician Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months? Month Year Pregnant at time of death Yes 2 X No ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No certificate 1 Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Retirement examiner? Community Hospital Other: 2 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 🗍 (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifie 29c. License numbe 2 Ū December 18, 2009 D40216 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damis Denise Cullen, MD 3616 Littledale Road, Kensington, Maryland 20895

State

Registrar

31. Date filed (Month, Day, Year)

DEC 30

Registrar's Sigr

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3<u>0</u> Physician/ 2009 December Elizabeth Shreve Doris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17738 St. St. Inigoes St. Mary's Inigoes Road Social Security Number 6. Sex Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours 07/10/1930 Washington, DC Director 220-26-4855 79 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20684 17738 St. Inigoes Road USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2000 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Center for Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver 11 Life Enrichment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 O'Brien Douglas Elizabeth Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14984 Point Lookout Rd., St. Inigoes, MD 20684 Deborah Fairfax/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State 01/02/2010 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD Brinsfield-Echols Signature Fuseral Service Trensee
Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons. q Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician. The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last ned by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy performed? Yes 2 No this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) မ 1 Tyes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work' 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres 40900 Merchants Lane, Leonardtown, MD 20650 Schmidt, D.O. 31. Date filed (Month, Day, Year) Registrar's Signature State IANO 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:28 AM **Physician** 09 27 Shurt Adrian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore Baltimore City dt Maryland Medicy If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number Vear) **Funeral 1** M 2□ F Months Days Hours 07/03/1975 Washington, DC 216-19-3417 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a fredical Examinat must be multipled at 1 XYes 2 No Director Prince Georges Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20745 2128 Alice Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Ye ar or Dates: 1 Never Married 2 ☐ Married 1 □Yes 2 □XNo Specify: Specify: þ **Black** 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automotive Sales Person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be filk if Health and Mental Hy item 27 is marked oth Be Ponjola Butler Short Anthony Short မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18419 Barney Drive, Accokeek, Maryland Ponjola Short/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages ' permit. Pages Department of Important: If it any injury or o to 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/04/2010 Waldorf, Maryland Trinity Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Lydia C. Thornton Johnson M00583 22. Name and Address of Facility. Thornton Funeral Home, P.A. 3439 Livingston Road, Indian Head, Maryland 2064 21. Sign eral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gastric Vicer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner B-cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical as attending IF FEMALE 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year for 5 ☐ Other (specify) Pregnant at time of death ed by the a detached f □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo has page 2 2 1/40 certificate 1 ☐ Yes 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes this Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? To the Hospital or Attending Pleating 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral After t (Month, Day, Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State

Baltimore, Maryland 21215-0036

P.0.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 2009

Adam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

32. Registrar's Signature

South

29c. License number

7586232

29d. Date signed (Month, Day, Year)

Greene St. Bultimore, MD 2/20,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time o 5:34 AM Physician/ David Snyder December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bottimore Workington Medial Anne arund Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 9. 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) West Virginia 1 ★ M 2 □ F 215 66 6556 50 Director 1959 Usual Residence of Decedent 23a or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Tes 2XXNo Capitol Heights Prince George' 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with United States 20743 313 Rollins Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 \square Never Married 2 \square Married 1 ☐ Yes 2 X No If Yes, Give \$ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Construction should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edna Harris W. Snyder, Sr. Richard permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Mother) Edna Ford 313 Rollins Ave, Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State Heritage Cemetery Dec 31, 2009 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Fome, Inc 6633 01d 21. Signature of Funeral Service ense Alexandria Ferry Road, Clinton, MD 20735 lit 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Septic Pnysician/ disease or condition resulting in death) Medical Examiner acute rena Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury e to or as a conse uence of Examine the attending physician and hed for use as the burial-transit neuminia that initiated events Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? aneuryon with recent rurgical repair 2 No 3 Probably 4 Unknown 1 🗌 Yes valve replacement; acute ver printing failur; 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an acte heratic failure 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ဂ္ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending М ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DO 022483 Recember 22, 2009 cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

Hospit

305

32. Registrar's Signature

LECURE

.. JACOBS MO

DEC 30

l b. Glen Burnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 26, 2009 CHRISTENE CORENTHIA WARREN KELTON SAVOY 1:01 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔽 F Months 70 214-32-9201 FEBRUARY 21, 1939 MARYLAND Director Yrs. Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND **CHARLES** WALDORF 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20603 11060 WEYMOUTH COURT #112 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 【**X**No If Yes, Give Year or Dates. 1 Yes 2 X No Specify "natural", Specify: BLACK 3 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry CHARLES COUNTY DEPT. (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) 2 YEARS OF SOCIAL SERVICES SOCIAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ YELLIE YANCEY WARREN LAURA ETHEL ROSS WARREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 sl f Health a item 27 i C. CECELIA KELTON / DAUGHTER 2973 MARSH HAWK DRIVE, WALDORF, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 Department of Important; If it any injury or o X Burial 2 Cremation 3 Removal from State PLEASANT GROVE CHURCH CEM. JANUARY 2,2010 MARBURY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 Signature of Funeral Service Licenses LYDIA C. THORNION JOHNSON M00583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATherosc Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2- No ပ္ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

29b. Signature and title of certifier

Mr SiL

31. Date filed (Month, Day, Year) DEC 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

11701

32. Registrar's Signature

DE5365

living Stan NI 4 (of for Achiston M)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ye ar Physician Michael Sushko Dec.25 2009 10:15p^M /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Hebrew Home of Washington If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 060-26-5138 1⊠ M 2□ F 90 Slovakia Oct.10,1919 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinating is ust by notified at Silver Spring 1 □Yes 2 No Montgomery Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20906 USA Berkenhead Court 3606 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No þ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't Russian Language Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Sushko Mary Sushko ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orest Holowka/Executor 2721 Abilene Drive Silver Spring, Md 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ RemovaLfrom State Rock Creek Cem. 12/30/2009 Washington, D.C. 4 ☐ Donation Geral Service Licenses 21. Signature of PHILTP AD RTWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Congestive heart failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ bleed, anasarca, history of stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident

To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records. After 1 after death.

I Director: Af d in by the fur

within 24 hours a

To the Funeral C

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifler

6 Could not be

29c. License number

D47794

29d. Date signed (Month, Day, Year) U

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Connecticut Avenue Kensington, Md 20895 Karen Rabin MD

31. Date filed (Month, Day,

3 Suicide



Medical

State Registrar

			1 - For State Of Mar State Of Mar Registrar	-	partment of Health Certificate of Deat		ental Hygiei Reg.	-211119	43276
	Physicia		1. Decedent's Name (First, Middle, Last) Margaret T.	Steele				Day Year 26, 2009	3. Time of Death 1:00 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	breere	4b. City, Town, or Locatio			4c. County of Dea	
1			Wilson Health Care Center		Gaithersbu	urg		Montgo	
	Funeral		1□M 2FTF	(In yrs. last birthd	Months Days Hours		8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
	Director		486-09-2866 Usual Residence of Decedent	99 Yrs	·		August 2,	1910 K	ansas
	yland how			10c. City, Town or	Location				10d. Inside City Limits
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	death with the Maryland ims 23a or 28a-f show	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 23a		415 Russell Avenue, # 512		20877			United S	
		/ Funeral	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ev. Armed Forces? 1 □ Yes 2 ☑ No.	er in U.S.	 Was Decedent of Hispanic of If Yes, specify Cuban, Mexical 1 ☐ Yes Yes 2X No Specify Cuban, Mexical Image: 1 ☐ Yes 		cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
5-0036	hours after tural", or ite	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 K No Speci	ary:		Specify:	White
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7	filed within Hygiene. other than " ent, the Me	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	,	ice President		Sh	irt Fold: Compa	ing Machine
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Jan		To B	Edward F. Murr	ohy			Theresa	Bader	
<u> </u>	g E E		19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street and Nun			ty or Town, State,	Zip Code)
e, e	s 1 and 2 should of Health and Mer Item 27 is merke other treumatic		Judith W. Steele/Daughter		Hampshire Ave				
9	ges 1 It of H If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other place)	Da	ite 20c	. Location - City or	Town, State
Бапптог	t. Pac rtmen rtant:		4 ☐ Donation 5 ☐ Other (Specify)	Metropo	litan Cremator	y 12/2	9/09 Al	exandria	, Virginia
g D	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tre		21 Signature of Funeral Service Licenses	2.4.1	22. Name and Address of Fac				00077
			23a. Part 1. Enter the disease, or complications that caused the		10 East Deer P				MD. 208// Approximate
-	Physician	i a	shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
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5	ng Ph ter th	-	27. Manner of Death 28a. Date of Injury	28b. Tim	e of 28c. Injury at		Bd. Describe how i		
SION	eath. or: A	Satic	2 Accident investigation		M 1 □Yes 2	□No			
	after date of Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, (Specify)	street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or F tate)	lural Route Number,
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. Within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and bompletely filled in by the funeral director, page 2 should be detached for use as the buriel-transit.	Medical C	29a. Certifier 1 Certifying Physician: To the best of examiner: On the basis of examiner and manner state	examination and/o	eath occurred at the time, date or investigation, in my opinion, o	and place, a death occurre	nd due to the caus d at the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
	within Somp	Me	29b. Signature and title of certifier) \	29c. License numbe	er .	29d.	Date signed (Mon	
	25		30. Name and address of person who completed cause of dea	th (Item 23a) (Tu	De Print)	294		Dreemle	1 26, 2009 1 2018
			John R. Melaic M	5	11 Rune / A	e 6	githeis	m, Me	l, 2018
	Sta Registra		31. Date filed (Month, Day, Year) 22. Registrar	s Signature	al d			1	
			BEO RO LOUS SERENCE	15. 140 a	W. C.				

State of Maryland / Department of Health and Mental Hygiene 2009

43277

Physician/
Medical
Examiner

Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou

Baltimore, Maryland 21215-0036

Physic Me Exan

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

		Registrar			Cer	tificate	e of L	Death		Reg. No.				
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camin	er	4a. Facility Name (if not institution Montgomery Ho		•	e	-		rLocation o ille	of Death			4c. County Mo	of Death ontgo	omery
neral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th Von	r)	9. Birth	place (State or Foreign
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ner		11. Marital Status	12. Was Deci	edent Ever in U.S prces?	i. 13. V	Vas Decec	dent of H	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			e - Americ ck, White,	can Indian,
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e e	ᅙ	Vasily A. Ula	•		18. Mother's Name (First, Middle, Maiden Surnam Ksenia Ulanova							5)		
mati		19a. Informant's Name/Relations			400 14.75		-01001					- T	24-4- 77-4	2-1-1
any injury or other traumatic event, the Medical Examiner must be notified at once.		Marina V. Burm		nter						<i>,</i> Ashbu				
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E 6		/ clest /	1 1		22. Name and Address of Facility Francis J. Collins Funeral Home In 500 University Blvd. W., Silver Sp									ng, MD 20901
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									Approximate Interval Between
cian/		Immediate Cause (Final disease or condition		crointes	tinal	Stro	mal	Tumor					ŀ	Onset and Death
dical		resulting in death)	a								_	TO MOS.		
niner		Due to (or as a consequence or):												
+	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	ence of):									
trans	хап	Cause (Disease or iinjury that initiated events	С	the to large a consequence of										
		resulting in death) Last Due to (or as a consequence of):												
ise as the burial-transit	n/Medical		d										_	
e as	ĕ	IF FEMALE:	000 15.000 000									Ì		
	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregnar Birth 2 - Feta	Ideath 3	Ectopic	pregnand	су					ite of deliv	ery Day Year
hed f	Physicia	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	g Unk	gnant at time of d nown	leath 5 ∟	Other (sp	pecify)					IVIC	211611	bay roai
letac	P	Part II. Other significant condition	ons contributing to	death but not resu	ulting in the u	nderlying	cause giv	ven in Part	I.	23e Did t	obacc	o use cont	ribute to t	he cause of death?
bed	by	3	3		,	,	,							bably 4 Unknown
pinor	etec													
e 2 st	Completed									24a. Was auto	psy		prior to co	psy findings available empletion of cause of
pag	Cor		<u> </u>							perfo 1 ☐ Yes	2 C	No	death?	2 🗆 No
actor,	Be	25. Was case referred to medical examiner?	Hospital:					lace of Dear	th (Check	only one)				
al dir	<u>و</u>	1 Yes 2 X No	1	Inpatient 2				4 ∐ Nι		me 5 🗆 Resi				Mospice
uner	ate:	27. Manner of Death 1 ★★Natural 5 □ Pendir	1g 28a. Date	of injury oth, Day, Year)	28b. Time of injury		8c. Injur! work	</td <td></td> <td>28d. Describe</td> <td>how in</td> <td>jury occurr</td> <td>red</td> <td></td>		28d. Describe	how in	jury occurr	red	
the	tific	2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could	not be		, ,	M		Yes 2						
in by	Certificate:	4 Homicide determ		e of Injury - At ho ling, etc. <i>(Specify)</i>		et, factory	, office			28f. Location (City or To			er or Rura	l Route Number,
filled		29a. Certifier 1 To Certifying	Physician: To the	hest of my knowle	edge death o	occured at	the time	date and	place an	d due to the	Heo/e/	and man-	er ac ctat	2d
completed filled in by the funeral director, page 2 should be detached for u	Medical	(Check 2 <u>□</u> Medical E	xaminer: On the ba Nurse Practioner:	i and/or invest	igation, in	my opinio	on, death oc	ccurred at	the time, date	and pla	ice, and du-	e to the ca	use(s) and manner stated.	
CO		29b. Signature and title of certifie	Nd-			290	. Licens	e number			29d. l	Date signe	d (Month,	Day, Year)
		1.00	OHO		<u> </u>			D296	75		De	ecemb	er 28	8, 2009
		30. Name and address of person Ralph V. Boco		se of death (Item 6420 Ro		,	ive,	Beth	esda	, MD 2	081	7		
Stat	е	31. Date filed (Month, Day, Year)	3£. F	Registrar's Signat		-								
gistra	r	DEC 29 2	2009 2	va B.	Mar	Mary .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle_Last) 2. Date of Death 3. Time of Death Day Month 2 **Physician** 375 AM wen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Mandrin House H.O.C. Anne Arundel Harwood If Under 1 Year | If Under 24 Hrs. 6 Sex **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days Hours 1 XM 2 F Director 217-42-7898 64 18, 1945 Washington, DC Aug Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Director 1 X Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tenth of Health and Mental Hygiene.
Intelf if the ZT is marked other than "natural", or items 23a or 3 may or other traumatic event, the Medical Examination iny or other traumatic event, the Medical Examination in the second of the s 651 Burton Cove Way 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 ∐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Promotional Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Sobel ၉ Rosalyn Rice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela A. Harvey/Wife 21132 Dray Terrace Ashburn, Virginia 20147 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Judean Memorial Grds: 12/29/2009 Olney, Maryland 21. Signature of Funeral Service Licensee Melissa Greenhut 22. Name and Address of Fabranzansky-Goldberg Memorial Chapel Millarenny 1170 Rockville Pike Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -9001 HRA5 disease or condition resulting in death) /Medical Due to (or a do consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Day Year Month 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2 🗓 No 1 □Yes 2 ▼No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\textstyle \text{Other (Specify)} \) 1 Yes 2 No MUSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; A: completely filled in by the fu death. investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated

State Registrar 29b. Signature an

31. Date filed (Month, Day, Year)

DEC 29

de of cextifier

ress of serson who completed cause of death (Hem 23a) (Type, Print)

Registrar's Signature

29c. License number

D63277

29d. Date signed (Month, Day, Year)

20 Suite 300 Annigolis MO ZILIN

			Please	State of Maryland					•	
			1 - For State Registrar	otato or marylana	-	rtificate of			neg. No 2009	43279
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ith Day Year	3. Time of Death
μ3.	/Medi	cal	Denotria 4a. Facility Name (If not institution, give			4h City Tourn	r Location of Deatl	12-21-	-2009 4c. County of Dea	9:30 a M
1	Examir	ier	Cherry Lane Nurs			Laurel	r Location of Deat	1	Prince G	
-	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		579-42-2486 Usual Residence of Decedent	99	Yrs.			07-04-1	910 Mis	sissippi
	yland now at		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	8a-f s	Funeral Director	DC	Wa	ashin					1 X Yes 2 □ No
	with the a or 2 the no	Dire	10e. Street and Number	NT TT		10f. Zip Code			10g. Citizen of What Co	ountry?
	ms 23	nera	818 Gallatin St. 11. Marital Status	12. Was Decedent Ever in U.S.	. 13.	20011 Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	U.S.A 14. Race - Ame	
98	or ite	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give		iryes, specify Cuba 1 □ Yes 2 □ YNo	an, mexican, Pueri Specify:	to Hican, etc.)	Black, Whit	e, etc.
Ö	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	ed by	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:		dent's Usual Occup			B1 16b. Kind of Business	ack (Industry
215	within 72 ene. than "na he Medic	plet	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	durina most of wor	rking	Tob. Idild of Business	muddiy
21	ed wit ygiene yer tha	Completed	12th		House	ekeeper			Self-Emplo	y e d
and	the fill he ed off	Be	17. Father's Name (First, Middle, Last) Arthur Carter)				ne (First, Middle, e Miller	Maiden Surname)	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			r, City or Town, State,	Zip Code)
	tem 27 Is other trau		Karl White (Grand-Son)	9639	Muirkirk	Road Lau	rel Mary	land 20708	
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any Injury or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	001	ice of Dispo metery, crea	sition (Name of matory or other plac		Date	20c. Location - City or	Town, State
Ħ.	permit. Pages Department of Important: If ite any Injury or of once.		4 □ Donation 5 □ Other (Specification of Specification o		Line			9/2009	Br en twood, Fu nera l H	Maryland
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	4 6		23a. P Enter the disease, or composit, or heart failure. List only	plications that caused the death.						Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conse fee	ence of):					
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	ecuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
760,	be executed sician and burial-transit	al Ex	resulting in death) Last	Due to (or as a conseque	ence of):					
687	death certificate b attending physic			d						
Вох	h certi ending use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnand		∃Ectopic pregnancy	,		23d. Date of de	livery
	0 0 0	sicie	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of dea		Other (specify)	<i>-</i>		Month	Day Year
P.0	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions of	contributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	quires n sign ald be	d by						1 □ Y	′es 2□No 3□P	robably 4 Unknown
000	aw require ts been sig 2 should b	plete						24a. Was a	an 24b. Were a	utopsy findings available
Ä	The ate h	Completed							rmeat? death? 212 No 1 ☐ Yes	completion of cause of
Vita	Attending Physician: The lav r death. ector: After this certificate has by the funeral director, page 2.	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	er ./	ath (Check only or		
o	g Phys er this eral dii	7: To	1 ☐ Yes 2 ☐ No 27. Many fer of Death	28a. Date of Injury 2	R/Outpatier 28b. Time o	IL 3 LI DOA	4 Mi Nursing F		ience 6 Other (Speciow injury occurred	ecify)
ion	afh. or Afte	ation	1 ☑ Natural 5 ☐ Pending investigation		Injury		k? Yes 2∐No			
Division or Vital Records,	or Attu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or Porn, State)	ural Route Number,
	To the Hospital or Attenswithin 24 hours affer death To the Funeral Director completely filled in by the	al Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowl	ledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) and manner a	s stated.
	To the Hospital within 24 hours в To the Funeral I completely filled	Medical	(Check only 2 Medical Exar	niner: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	ppinion, death occ	urred at the time,	date and place, and du	e to the cause(s)
	To the Company	Ž	29b. Signature and title of certifier	1	0	29c. Licens	e number		29d. Date signed (Mon	
			Hrobes V	larger M	D_		5105	/ /)ecember	22, 2009
R	10		30. Name and address of person who	completed c use of death (Item 2	3a) (Type,	Print) Llac	u Rd	Ellicot	t city N	22, 700g
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	- igo	" / "	CVIIWI	11/1	7.0
	Registi	ar	BEC 3 0 2009	knew B. Jac	Ros					

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 43280 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Smi Physician/ Je3 1440M MMA GRACE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 7018 Wake Forest Drive College Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** 1 DM 2 F Months Days Hours Min. 577-05-9954 91 Yrs Butler, Director March Ĩ′918 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Prince George's 1 X Yes 2 No College Park Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7018 Wake Forest Drive 20740 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Attorney Legal Secretary 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk and Mental ! is marked o မ Edna Martin Oliver Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sandra C. Ahalt / Daughter 2527 Lyon Drive, Annapolis, MD 21403 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 1/9/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 ton Jas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or impury and-trans that initiated events resulting in death) Last Due to (or as a consequence of): -burialng physician as the burial Physician/Medical death certificate be attending p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year the be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has yes 2 No certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gentlying hurse Practioner: It is a cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gentlying hurse Practioner: It is a cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 orly and) A batata as na man bna (s)eau 29b. Signature and title of certifie 21438 completed cause of death (Item 23a) (Type, Pr ame and address of person ANNAPORS MORIFUI alENA M 44 DEFENSE State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month Roger Earl Tyler 2009 22 1:15a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Talbot 105 W. Chew Avenue St. Michaels If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 81 213-24-0606 Yrs. Director 7-31-1928 Md Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "naturel", or Items 23s or 28s-f show the Medical Expressmust by notified at Md 1 XYes 2 □ No St. Michaels Director Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 105 W. Chew Avenue 21663 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ŽŽŽXo If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 swimite 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet other then Elementary/Secondary (0-12) College (1-4or 5+) Retail carpet installer 11 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe eny Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Edwin Earl Tyler Thelma Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 W. Chew Ave. St. Michaels, Md. 21663 Margaret K. Tyler wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 12-23-09 Dover, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. C.F.S.D Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic acciden **Physician** cerebrovascular 1000 /Medical Due to (or as a consequence of). Examiner Car abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attanding esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the sate has been signed by page 2 should be datacl Part II. Dither significant conditions contributing to death but not resulting in the undertying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24a. Was an autopsy performed? 1 Yes 2⊠No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo ٥ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie nathan DO 57749 MD December 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RS 4 State

Registrar

219 S. Washington St. Easton, Md. 21601 Md. Lakshmi Vaidyanathan, 32. Registrar's Signature

10+VA

State Registrar

LUDWIG J. EGLSEDER 31. Date filed (Month, Day, Year) **DEC 29 2009**

29b. Signature and title of certifier

30. Name and address of person who complete

503 CYNWOOD DRIVE, EASTON, MD

cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

21601

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}0, Physician/ December 2009 7:46 a M Trossbach, Sr. Bernard Medical Joseph 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours June 20, 1938 Country)Maryland Director 71 214-38-1173 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland St. Mary's Dameron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20628 USA 17534 St. Jeromes Neck Road death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 K Married þ Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Bernard Edgar Trossbach Nettie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 28, Dameron, MD 20628 Rita C. Trossbach/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Michael's 01/04/2010 Ridge, Maryland 21. Signature of Shyd Licens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final neumoma Onset and Death Physician disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Lack Examine ngv S attending physician and for use as the burial-tran resulting in death) Last disease Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day ned by the a detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed Yes 2 1 death? 1 Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 A No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 124 hours a Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certif. 29c. License number 29d. Date signed (Month, Day, Year) 09 0 ema 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panwala, M.D. 37767 Market Drive, Charlotte Hall, MD 20622 Manoj 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2:30 TYRONE TAYLOR 2009 12 27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY, MD CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, 08–12–1960 7. Age (In yrs. last birthday) **Funeral** Hours Wash. DC 1 XM 2□ F 49 **Director** Usual Residence of Decedent 10d. inside City Limits 10a. State 10b. County 10c. City, Town or Location Items 23a or 28a-f show Capitol Heights 1X Yes 2 No MD PG Director 10f. Zip Code 20743 10g. Citizen of What Country? 10e. Street and Number 6623 Sisalbed Dr. USA by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Specify: Black d other than "natural", or i altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any injury or other traumatic event, the Magnesian pages. Elementary/Secondary (0-12) College (1-4or 5+) Income Tax Consultant Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Fredia E. Jones David L. ပ္ 19a. Informant's Name/Relationship (Type. Print)
Fredia E. Taylor/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6623 Sisalbed Dr. Capitol Heights, MD 20743 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Pk Crematory 12-30-09 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 Koonal Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NON-TRAUMATIC INTRACEREBRAL BLEED 20 CVA **Physician** <24 Hrs. disease or condition /Medical Due to (or as a consequence of): Examiner ARRE ARDIAC Esquentiemy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: N / S 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery N/B th 3□ Ectopic pregnancy 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Month 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HIV / AIDS Completed ANAEMIA 24b. Were autopsy findings available prior to completion of cause of death? MACROCYTIC 24a. Was an autopsy NIB BACTREMI Coas 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No ours after death.

leral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠(No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural NIX NIX 1 ☐ Yes 2 ☐ No 2 Accident X 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide NIR 24 hours a 🗜 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier dalir Kah D-69218 09

State Registrar 3001, HOSPITAL 31. Date filed (Month, Day, Year) DEC 3 0 2009

Suite # J-500. 32. Registrar's Signatu

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LALIT KALRA, MI)

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timore, Maryland 21215-0036

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			23a. Part 1. Enter the disease, or complicat is that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List inly one cause on each line.	rdiac or respiratory arrest, Approximate Interval Between Open and Death
1	Physician		Immediate Cause (Final disease or condition a Seizure 1)507001	- 30 hours
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Disease 2 years
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	cuted Id ansit	Examiner	53 quantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
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rds	quires an sign uld be	ed b		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
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of	Phys rthis ral dir	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ng Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
ion	nding tth. :: Afte e fune	atio.	1 ☑ Natural 5 □ Pending (Month, Ďay, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
Division of	l or Atter after des Director	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of ceptifier 29c. License number	29d. Date signed (Month, Day, Year)
	FSFO		Selfmill mo Do050	6/2 December 21, 2009
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
R	2		Dr. Maller- 9701 Veirs Dr., Rockville, M	d.20850
	Sta Registr		31. Date filed (Month, Day, Year) DEC 3 0 2009 Level 5. Against	
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)	Examin	er	4a. Facility Name (if not institution, give stree Shady Grove Adventi			4b. City, Town, or Rockv11				unty of Death Ltgomer	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	g, Birth	place (State or Foreign
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Jore ge 1a	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Rem	noval from State 20b. P	lace of Dispo: emetery, crem Metror	sition (Name of natory or other place OOLItan OOLY	Decen			tion - City or T	
Baltimore, permit. Page 1 and	artmer ortant injury e,		4 Donation 5 Other (Specify) 21. Signature of Funeral Syrvice Ltc, ns. e			OTŸ . Name and Addres					Virginia
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VITS hysicia	his cer I direct	P B	examiner? 1 Yes 2 No Hosp	1 L Inpatient 2	ER/Outpatier		4 L Nursing Ho	ome 5 Resid	dence 6	Other (Speci	fy)
fing P	r. After tl funera	ate:	1 Aatural 5 ☐ Pending	28a. Date of injury ((Month, Day, Year)	28b. Time of injury	work		28d. Describe h	ow injury o	ccurred	
Sion	r death	Certificate:	2/☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho	me, farm, str		165 2 110			lumber or Run	al Route Number,
Div	irs afte al Dire led in t			building, etc. (Specify				City or Tov			
Hosp	24 hou Funer eted fil	Medical	(Check 2 Medical Examiner:	n: To the best of my know On the basis of examination actioner: To the best of my	n and/or inves	tigation, in my opinic	on, death occurred a	t the time, date a	and place, ar	nd due to the c	ause(s) and manner stated.
To the	within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Σ	only one) 3 LJ Certifying Nurse Pi 29b. Signature and title of certifier	actioner. To the best of fig	, Allowiedye, (29c. License		se, and due to th		signed (Month	
	3		#189/201	YD		03	7024		Dec	enge	x373009
•			30 Name and address of person who comp	pleted cause of death (Item 901 Medic	1 23a) (Type, F	Print) Paker)	rive Ro	Lvill	e M	0 3	20850
	Sta Registr		31. Date filed (Month, Day, Year) DEC 29 2009	32 Registrar's Signa	1. 40	Med.					

State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year William Edward Wolfe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton 5909 Clover Leaf Ave If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 5, **Funeral** 1 M 2 □ F Months Days Hours Min. Director 184 44 3657 57 Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examiliar must be notified at 1 ☐ Yes 2 No Directo Clinton Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20735 5909 Clover Leaf Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. within 72 hours after 1 □Yes 2 No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 1 10 þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Customer Service Utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Mary Fitting Miles Wolfe Department of Health and uportant: If item 27 is m. y njury or other terms. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie DeMaroney (Niece) 4790 Lake Park Terrace, Acworth, Ga 30101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State permit. Page: Department o Important: If any Injury or Clinton, MD Lee Crematory Dec 31, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d 21. Signature of Funeral Service Licensee Jours (1) rand MO0257 Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Complications **Physician** Human /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed tran and physician and the purial-t Due to (or as a consequence of) Box 68760, Physician/Medical use as attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 힏 in the past 12 months? Month 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: rector, 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1- Natural 5 Pending investigation death. Director: / d in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours aft

To the Funeral Di

completely filled ir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 23 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year, Registrar's Signature State 30 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physician/ 1450 2009 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional estern MD egan Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday 1 № M 2 🗆 F (Month, Day, 577-06-1596 Director Usual Residence of Decedent than "natural", or items 23a or 28a-f show ne Medical Examiner must be notified at 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 又 USA 0019 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Am Married ð Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: BIACK If Yes Give Specify 3 Divorced 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the UNEMP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WA 19a. Informant's Name/Relationship (Type, Print) WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNEELLA WASHINIGT 14 ax 25 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o ō ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 12-31-09 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 1+0150 W. ILLOWS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastako Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Examine Due to jor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No ģ Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate has 2 1 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 No 1 Tyes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) SANIKOTTU 2009. SUDKEER 00069737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTERNARYLAND HEALTH

Registrar

State

31. Date filed (Month, Day, Year)

2. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 25, per ME g899 1/25/10 TT
For Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 28 2009 12:38P M Whitley Ernest Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.

Appths Days Hours Min. 8. Date of Birth (Month, Day, June 20 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ KENTUCKY Director 402-72-4357 58 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director MD Prince George's Cheverly 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6006 Reed Street 20785 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 No Army Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black. Specify: 3 Widowed 4 🙀 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Private Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John B. Helms Beulah Whitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Reed Street Cheverly, Maryland 20785 Vickie E. Helms/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lynch Cemetery 1/2/2010 Middlesboro, Ky Signature of Funeral Service Licensee J. B. Jenkins Funeral Home 22. Name and Address of Facility 7474 Landover Road Landover, Maryland 23a. Part 1. Enter the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death temomn Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or). and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has performed Yes 2 To the nown....
within 24 hours all er death.

To the Funeral Director After this certificate I

- 1 → → ← filled in by the funeral director, pag 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No __ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ivertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertyling Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) DO0 55/20 m Dec 28 2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern avenue St Snote 310 Washington DC 20032 31. Date filed (Month, Day, Year) State **DEC 3 0 2009** del Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:00 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Pineview Clinton Prince George's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 🗆 M 2 💢 Maryland Months Days Hours Min. (Month, Day, Year) May II. 577-40-6837 Director 95 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director Maryland Prince George's 1 Yes 2 No College Park: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 United States 5006 Pierce Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African 3 X Widowed 4 Divorced Completed Year or Dates Americar 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) NSA Classified Government Be Page 1 and 2 should be filed iment of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Isacc Walls Hattie Ann Dyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Weems Ligon/Daughter Pierce Ave. College Park, Maryland other Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Dec. Date 29 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Maryland National 2009 Laurel, Maryland Funeral Service L 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Rd. NE Washington, 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Dav Pregnant at time of death Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate ha rfor 2 No 1 Tes Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 임 4 Nursing Home 5 Residence Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the fu death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) lame and address of person who completed cause of death (Item

State Registrar

DEC 3 0 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 4c. County of Death December 2 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Futurecare Homewood Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. Months Days 1 M 2 X F Yrs. Maryland 47 Apr 5, 1962 Director 220-78-4008 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Gwynn Oak Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21207 U.S.A. 1166 St. Agnes Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Unemployed Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown 2 Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 19a. Informant's Name/Relationship (Type. Print) Suite 200 Baltimore, MD Holloway & Sullivan Attorneys 10 N. Calvert Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cem. 1/8/10 Reisterstown, MD 21. Signature of Fungral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road m. outsins Stephen Reisterstown, MD ELINE FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 2 Records, 1 🗌 Yes 2 **X**No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an his certificate has by director, page 2 sh autopsy performed? 1 Yes 2 No lator Division or Vital il or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ပို After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Transferring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) on Edmondson 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

		1	For State Registrar	State of Ma	ryland		rtment o <i>tificate</i> (giene _{Reg.} No.	400	3 43294
			Decedent's Name (First, Middle, Last	it)						2. Date of De		Year	3. Time of Death
	Physicia /Medic	al		derson						Month Decembe	$\overline{}$, 2009	12:15A M
	Examin	er	4a. Facility Name (If not institution, give	e street and number)			4b. City, Tov	n, or Locatio	n of Death			,	
			Prince George's					andove	er ler 24 Hrs.	O Data of Piz			George's rthplace (State or Foreign
	Funeral		5. Social Security Number 6. S	ex 7.Age DXM 2□F		st birthday) Yrs.	If Under 1 Y Months D	ays Hour		8. Date of Bir (Month, Da	y, Year)	C	ountry)
	Director		369-12-5613	ZAIWI ZUI	87	YIS.				01/22/	1922		Ohio
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	or th	اجّا	10e. Street and Number				10f. Zip Co	ae			rog. Oili		ountry:
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9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinar munt to notified at	五	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ N If Yes, Give			I∐Yes 21∑					Specify:	White
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examirat must be rediffed at once.	P.	Jack Andersor	1					4	Helen	Gre		
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n)	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Domesial from State	20b. Pl	ace of Dispo metery, crea	sition (Name natory or othe	of r place)	1	Date	20c. Lo	ocation - City o	r rown, State
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot		4 □ Donation 5 □ Other (Specif		Mt.	Olive	et Ceme	etery	12/3	0/2009	Wash	nington	, D.C.
äĦ	mit. Sorta / Inju		21. Signature of Meral Service Lice	nsee		2:	2. Name and A	Address of Fa	acility Be	all Fur	neral	Home	
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Para Cara	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or my shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each lin a. SEPS S Due to (or as a CORONA* C. Due to (or as a Due to (or a) Due	a consequ	ence of):	y Dis						Interval Between Onset and Death
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O. Box	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal	death 3	☐ Ectopic preg ☐ Other (spec					23d. Date of o Month	delivery Day Year
Records, P.	e law requires that has been signed b e 2 should be deta	Completed by Ph	Partill. Other significant conditions	contributing to death but	ut not resu	Ilting in the L	inderlying cau	se given in P	art I.		tobacco]Yes 2		to the cause of death? Probably 4X Unknown
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no	ding h. Afte fune	lio I	1 Natural 5 ☐ Pending	(Month, Da	y, Year)	Injury	м	Work? 1 ☐ Yes	2 □No				
Division of Vital	or Atten after deat Director:	Certification: To	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	e lago Place of Init	ury - At ho c. <i>(Specif</i>)	me, farm, st	reet, factory, o	office			(Street a		Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examina	wledge, dea tion and/or i	th occurred at nvestigation, i	the time, da	te and place , death occu	, and due to the	ne cause(e, date ar	(s) and manner nd place, and c	r as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 7	- mykernen wa			29c.	License numb	ber		29d. D	ate signed (Mo	onth, Day, Year)
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	w.m		30. Name and address of person who		leath (Item		Print) SPITKI	AR		CHEVE	RIV	M)	20785
			DR JAMES CATE 31. Date filed (Month, Day, Year)	VENIS 32. Pégistr			JI II KI			-31- Y C	1	1111	,
	St Regist	ate		2009	Art 1	A. 1	Garker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise Atkins 2009 8:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 Hours Min. 475-20-7485 Minnesota **Director** 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2713 Riva Road 21401 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 🖾 No <u>გ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🙀 No If Yes, Give Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Folka Roy Emanuel Mickelson Ethel Jane Neeley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Crawford (Daughter) 2713 Riva Rd. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Atlantic Crematory 12/29/2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Medical resulting in death) Examiner pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Year ed by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þλ tailure 2 No 3 Probably 4 Unknown Completed many artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 s After this certificate has autopsy Cardiomyopa perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) P Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Accident the Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретен Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature and Ale of 12.28,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Partway #670 Anapolis MD 21401.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 3 0

Amended Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27 2009 3:00 December Harold Lee Baumgartner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Vear Months Days Hours ty⊡ M 2□ F 78 23, 1931 Wisconsin Director 312-28-5381 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, the Medical Exemiter must be redified at 1 ☐ Yes 2 ☑ No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2524 Uniontown Rd. Funeral 21158 12. Was Decedent Ever in U.S Armed Forces? 104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1948 1 Syes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married SOUMOONTHEN HA Baltimore, Waryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: \$ 1950 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Builder-Developer Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Injury or other traumatic 2 Raymond Baumgartner Elva Mae Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Wife 21158 Marilyn Baumgartner 2524 Uniontown Rd. Westminster, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12/31/2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Paul's Cemetery 1/31/2009 Uniontown, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licen 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con a guence of) the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Por Dav 5 ☐ Other (specify) 1 □Yes 2 □ No P.O. this certificate has been signed by the al director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐Yes Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ٩ 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Towsa eath (Item 23a) (Type, Print) 10 Charles St. 31. Date filed (Month, Day, 32. Registrar's Signatus State Registrar

DHMH 17 Rev 1/2001

In home

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar **Physician** BRAXTON -UCILLE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY GENERAL HOSPITAL MONTGOMERY DLNEY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Director <u>217-42-2353</u> 98 05/03/1911 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? ō 14600 Good Hope Road 20905 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Wedfert Example any once. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Presley Awkard Martha Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14604 Good Hope Road, Silver Spring, MD 20905 Richard Braxton, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State FD Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. Cemetery 1/4/10 Sandy Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home usus ₹246 N. Washington St. Rockville, MD 20850 23a. art1. Enter the disease, or complex tions that caused the death. Inot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENSION **Physician** Years /Medical Due to (or as a consequence of): Examiner DISEASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Anous after death.

Lahoural Director: After this certificate has been signed by the attending physician and retely filled in by the funeral director, page 2 should be detached for use as the burla-transit MYO CARDIAL INFARCTION Due to (or as a consequence of) Physician/Medical HYPER LIPIDEMIA 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown STROKE HYPOTHYROIDISM Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50276 DECEMBER, 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SANGEETA SIMLOTE, MD 3411 OLANDWOOD COURTS, SUITE 105, OLNEY MD 20832 3. Registrar's Signature

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау **Physician** CLARENCE M. BOATMAN 12/26/2009 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9. Birthplace (State or Foreign Country) Silver Spring Atrium Classic Home 5. Social Security Number If Under 1 Year If Unde 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days 241-09-9150 90 Director 03/09/1919 NC Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 133 Ritchie Avenue USA 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1942-1944 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Exemi 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No ģ Specify. Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Dept. of Defense Cartographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angus Boatman ပ Celia A. McMillian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cedric L. Boatman - son 1948 Flowering Tree Terr., Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 01/02/10 Rockville, MD 21. Signature of Funeral Service Lisen 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the dise se, or com shock, or heart failur. List only cations that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multi-infarct dementia vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Seizure disorder 24a. Was an autopsy performed 1 □ Yes 1 ☐Yes 2 ☐No 2/ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To uneral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide

P.0. Division of Vital Records, ieral Director: /

e Funeral within 2 To the I

10810 Connecticut Avenue, Kensington, MD 20895 Jeffrey Don Drobis 31. Date filed (Month, Day, Year, 32 Registrar's Signature State DEC 31 Registrar

and manner stated.

no completed cause of death (Item 23a) (Type, Print)

determined

4 Homicide

29b. Signature and the of cer

30. Name and address of perso

29a. Certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D18137

29c. License numbe

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12/28/09

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Wilmer LeRoy Barnes 25, December 2009 4:10 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll 4757 Ruggles Road Taneytown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Days 1**X**M 2□ F 91 214-01-0569 Jun 25, 1918 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Carroll 1 ☐ Yes 2 No Maryland Taneytown 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 4757 Ruggles Road 21787 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 ▼No Specify: Specify: IIWW white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Tool & Dye Maker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Barnes Minnie Little 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy K. Barnes, wife 4757 Ruggles Road, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Piney Creek Cemetery 12/30/2009 Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural", or items 23a

than

of Health and Mental Hygie item 27 Is marked other other traumatic event, It

permit. Pages 1
Department of P
Important: If ite
any Injury or ot
once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

physician and the burial-tran attending p signed by the a certificate has I s after death.

I Director: A id in by the fu

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Completed by Physician/Medical Be Certification: To

within 24 hours af

To the Funeral D

completely filled in To the Hospital

State

Registrar

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

29c. License number

28c. Injury at

Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

cole Rd. Wistminster 31. Date filed (Month, Day, Year)

DEC 28 2009

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

2 Accident

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 18 2009 11:59p^M Jean Esther Bailey December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country)
Canada 8. Date of Birth (Month, Day, NOV 02 5. Social Security Number . Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🕱 F 91 **Director** 215-24-1224 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits event, the Warfical Examinar must be notified at 1 □Yes 2√E No laryland Carroll Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2261 Old Westminster Pike 21048 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ò White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Brunton Jabez Elul Sidaway ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is,
any injury or other trau 5300 Sweet Air Road Baldwin, MD Jack Bailey/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sandy Mount Cemetery 12/23/2009 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Prints Artheraly Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** reoh /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 ma Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 2 No 1 ☐ Yes the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Tes No 3 Probably 4 Unknown Completed been 8 24b. Were autopsy findings available prior to completion of cause of death?

1. ☐Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 2/ 1 ☐ Yes Be 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 F Other (Specify) Medical Certification: To this 27. Mann of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Accident atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ည 1 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 555 wat 31. Date filed (Month, Day, 32. Regetrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FORMEND#20B per FH
State Of Ivial year
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State Of Ivial year Certificate of Death Reg. No.2 Decedent's Name (First, Middle, Last) 2 Date of Death Month 2009 Dec. 24 1:45 РМ Frances Brown 4b. City, Town, or Location of Death 4c. County of Death Churchton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Birthpic Country) DC Days Months Hours Min 1/14/1952 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Churchton 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 20733 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify White Specify. 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Frances B. MacLean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 5629 Dartmouth St. Churchton, MD 20733 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1/6/2000 Maryland Veterans Cem Crownsville, MD ce Licensee 22. Name and Address of Facility Hardesty Annapolis 1/2 12 Ridgely Ave. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death selero erib PAS Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 2 No 4 ☐ Pregnant 9 ☐ Unknown

28a-f shov important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 72 hours after death Baltimore, Maryland 21215-0036 should be filed v and Mental Hyg permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Physician/ *Medical Examiner that the death certificate be executed burial-tran ng physician a Box 68760 attending Jse : for led by the a detached f Division of Vital Records, P.O. signed to the Hospital or Attending Physician: The law requires thin 24 hours after death.

The Thours after death.

The Thoursal Director, After this certificate has been sign pieted filled in by the funeral director, page 2 should be within 2 To the I To the State

Funeral

Director

Physician/ Mary Medical 4a. Facility Name (if not institution, give street and number) Examiner 5629 Dartmouth Street 5. Social Security Number 219-64-9220 Usual Residence of Decedent 10a. State Director MD 10e. Street and Number Funeral 5629 Dartmouth St. 11 Marital Status 1 Never Married 2xXMarried þ 3 Widowed 4 Divorced Completed Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ၉ Walter E. Bowen Jr. 19a. Informant's Name/Relationship (Type, Print) Donald Brown 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral S 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? g Wunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify, 2 No ೭ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? injury 5 Pending 2 🗀 No Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland Registrar	Certificate of Death	Reg. No. 2009 43303
	Physici		1. Decedent's Name (First, Middle, Last) MARTIN はLAN	IKENSHIP JT. Dece	
80.3	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
0	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la:	SP BALTIMORE strbirthday) If Under 1 Year If Under 24 Hrs. 8. Date of	of Birth Day, Year) 9. Birthplace (State or Foreign Country)
	Director		214-24-2560 1\(\overline{\fmathbb{M}}\) M 2□F 82 Usual Residence of Decedent		th, Day, Year) Country) unk
	ryland	_		Town or Location	10d. Inside City Limits
	the Ma	Director	MD Ba:	1timore	1√Yes 2 No 10g. Citizen of What Country?
	th with	al Di	838 Mt. Holly Street	21229	USA
215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be redilled at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Arged Forces? 1 □ Never Married 1 □ Never Married 1 □ Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: white
15-(in 72 h n "natu fedicel	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
21	filed with Hygiene ther tha	Com	Elementary/Secondary (0-12) College (1-4or 5+) unk unk	disabled	none
and	ed d d	To Be	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, M	liddle, Maiden Surname) unk
, Maryland	nd 2 shoath and alth and 27 is m	-	19a. Informant's Name/Relationship (Type. Print) Bon Secours Hospital	19b. Mailing Address (Street and Number or Rural Route N 2000 W. Baltimore Street	
altimore,	mit. Pages 1 and autment of Heal ortant: If item 2 Injury or other Injury erether		20a. Method of Disposition 1	nce of Disposition (Name of Date metery, crematory or other place)	20c. Location - City or Town, State
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee Ronald Figure 1. Director	State Anatomy Board 655 Baltimore, MD 21201	W. Baltimore Street
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conseque Seguentially list conditions	Do not enter the mode of dying, such as cardiac or respirat F SPONTANEUS PER ence of); 515 LIVER	Approximate Interval Between Onset and Death
68760,	rificate be executed ig physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a conseque c. ARTERIOS Due to (or as a conseque d.	SCLEROTI'L HEART	DISTASE
89 x	.≒		IF FEMALE:		
.O. Box	Attending Physician: The law requires that the death certi roteath. ector: Affer this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of decent of the setal of	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
rds, P.	w requires that been signed to should be deta	þ	Part II. Other significant conditions contributing to death but not result - HEPATIL ENCEPHA - HYPSTHYROLDIS	ing in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
II Reco	The law re cate has be page 2 sho	Completed	- HYPOTHYROIDIS	IVE LUNG DISEASE 10.	Was an autopsy autopsy performed? Yes 2 ₱ No 1 □ Yes 2 □ No
Vita	yslclan: The is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of D	
n of	ding Phy h. After this funeral d	on: To		Talkaralig florite 3	Residence 6 ☐ Other (Specify) cribe how injury occurred
-	II or AttendI after death. I Director: A d in by the fu	Certification:	2 Accident investigation	M 1 □ Yes 2 □ No ne, farm, street, factory, office 28f. Locat City of	tion (Street and Number or Rural Route Number, or Town, State)
	Hospita 24 hours Funeral stefy fille	ical	(Check only 2 Medical Examiner: On the basis of examination	rledge, death occurred at the time, date and place, and due on and/or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (learn)	D 23300	Desember 24 2009
			SUDHIR, PAPEL,	2000 W. 13 m 1/0 3k. 1	3A272.1701.21223
	Sta Registr	te ar	30. Name and address of person who completed cause of death (Item 2 Sudden) 31. Date filed (Month, Day, Year) 32. Registrar's signature 3. A Sudden S	pare	

Registrar DHMH 17 Rev 1/2001

Byong Joon Chu		State of Maryla 1- For State Registrar	nd / Departm <i>Certific</i>			d Mental I		Reg. No. 200	9 4330	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Byong J. Chun					2. Date of Dea		3. Time of Death 1525 hrs	
		4a. Facility Name (if not institution, give street and nur 10391 Weatherburn Road	nber)	4	o. City, Town, or Woodstock	Location of Dea		4c. County of E Howard	Death	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days		lin	irth(MM/DD/YYYY) 9 29,1928	Birthplace (State or Foreign Country) S. Korea	
yland I-f show any	Ļ	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, Town		odstock				10d. Inside City Limits 1 Yes 2XX No	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) Soo Chun 19a. Informant's Name/Relationship (Type, Print)	. 1.42	N		Pi1	Lee	Maiden Surname)		
- P = E =	입	Yong Chun (Son) 20a. Method of Disposition		103		erburn		mber, City or Town, S ISTOCK, MD I 20c. Location - Cit	21163	
= 2 5 E E		1 Burial 2 A Cremation 3 Removal from 4 Domation 5 Other Specify:	m State crema	ntory or other	er place) Cremato	ry 12	/28/09		rnie, MD	
		21. Signature of Funeral Service Licensee Lauth 23a. Part I. Inter the disease, or complications that ca	Aff	72		ngton B	uneral H lvd. El		MP Inc. D 21075	
Physician /Medical Examiner		failure List only one cause on each line. Immediate Cause (Final disease a. Contact Gui	nshot Wound of		e mode or dying,	sucii as cardiac	or respiratory an	est, snock, or near	Between Onset and Death	
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uted nd ransit	Examiner	(Disease or injury that initiated C	consequence of):							
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ion of Vital Records, P.O. Box 6876(lending Physician: The law requires that the death certificate eath. for: After this certificate has been signed by the attending phy the funeral director, page 2 should be deached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	nt at time of death	2 Feta	l death 3 [er (Specify)	Ectopic pregi	nancy	Month	Day Year	
ires that the signed by the detache	2	Part II. Other significant conditions contributing to	death but not resultin	ng in the un	derlying cause g	iven in Part I.			e to the cause of death? Probably 4 Unknown	
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ion of tending Ph eath.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of FOUND: Dec 22, 2	Pay, Year) FOL	Time of Inj UND: 0 hrs		yatWork? es 2 ✔ No	28d. Describe Subject sho	how injury occurred ot self		
E 6 5	Certification:	3 Suicide 6 Could not be determined (Specify)	of Injury - At home, f Single Family	arm, street	factory, office bu	uilding, etc.	or Town, S		Rural Route Number, City	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the bast one) 2 Medical Examiner: On the basis or and manner sta	examination and/or		n, in my opinion,	death occurred				
	Σ	29b. Signature and title of certifier All	lan		29c. License O.C.N			29d. Date signed (December 26,		
		30. Name and address of person who completed cause Carol Allan, MD Assistant Medical E	,	Penn S	reet, Baltimo	ore, MD 212	01			
St		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Amended item#10f, WCHD, SL Certificate of Death 1. Decedent's Name (First Middle Last)	Reg.	2009	43305
Physicia	\mathbf{n}_{I}	1. Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death
Medical Examir		Elwood Gardner Collins, Sr.	December 2	26, 2009 4c. County of Death	2030 hrs
):		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 11206 Warwick Lane Princess Anne		Somerset	
Funeral			8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director		219-46-4496 X M 2 F 60 Yrs. Months Days Hours Min.	7-1-19	49 Foreig	untryMD
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .	_				1 Yes 2 No
faryland 28a-f show Latonce.	Director	MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.	힠	11206 Warwick Lane 2753 21853	U.	S.A.	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. 4 other than "natural", or items 23a or 28a-f she 5, the Medical Examiner must be notified 21 once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto R		14. Race - Ameri White, etc.	can Indian, Black,
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5-00 led with Hygiene other 1	틩	12 Production 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Last)		<u>Industrio</u> iden Surname)	<u></u>
O 8 2 3 E	a B	Walter Collins Marie C			
MD 2. d 2 should lth and M n 27 is m: sumatic e	-1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			
				MD 218 20c. Location - City or	
2 8 6 2 8		1 Name Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: MD Veteran's Cem 1/5/2	2010	Hurlock,	MD
Baltimore, permit. Pages l a Department of He Important: If ite	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	T	1 11 0	
		Bennie Smith 91/ Funeral Home Sal	isbury	, MD 2180) 1 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	copilato, y arroct	, one or, or mount	Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
	اة	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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3760, ficate b g physic s the business		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	~~	23d. Date of delivery	ay Year
Box 687(re death certifica the attending pl	sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		l World	vay teal
D.O. BO) that the deatl ned by the att detached for	솔.	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did toba	acco use contribute to	the cause of death?
P.O. es that the igned by be detach	2	Tark in Other Significant Conditions Continuously to dead particle estimate and entyring cause given in Fact.	1 Yes		ably 4 🗸 Unknown
Cords, P.C. law requires that has born signed b	e		24a. Was an autopsy		topsy findings available ompletion of cause of
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tal Rection: The certificate ector, pag	ğ Be	25. Was case referred to medical examiner?			
F Vit	힏	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Outsing		esidence 6 🗸 Other	Scene
Division of Vital Records, ra der death and Physician: The law require ra after death all Director: After this certificate has been siled in by the funeral director, page 2 should be		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Ves 2 No	isa. Describe nov	w injury occurred	
ivision or Atteno after death Director:	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. 2			ral Route Number, City
Divisor or posting or progression of the control of	Certification:	4 Homicide determined (Specify)	or Town, Stat	e)	4
	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and displace, and displace are considered by Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the constant of the constant			
To the within To the comple	Med	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mor	
a l		Carol Halla O.C.M.E.		December 27, 20	009
J81	1	30. Name and address of person who completed cause of death (Item 23a) Corp. M. M.D. Assistant Modical Examinary 1111 Page Street Politimary MD 21201			
Sta	le le	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·	1/
Registr		JAN 0 4 2010 Senus A. Sale			

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ORIGINAL

			1 - For State Registrar	State of Ma	aryland		artmer rtificat					Reg. No.	200	9	4330)6
ш	Physici	e an	1. Decedent's Name (First, Middle, Las	t)							Date of Dea Month	Day	Ye	ear	3. Time of Dea	th
	/Medic			toe							Decemb	er 2	29, 20	009	11:15	ρ ^M
	Examir	ner	4a. Facility Name (If not institution, give	,					Location of				County of I			
			Sacred Heart Hom 5. Social Security Number 6. S		e (In yrs. las	t hirthday)		atts r1Year	ville If Under 2		Date of Birt		ince		ge's ce (State or Fo	
	Funeral Director			M 2□xF	82 82	Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)		Country	1)	reign
	iand ow It		10a. State 10b. County		10c. City, 7	Town or Lo	cation							100	I. Inside City Li	mits
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ţ	Maryland Prince G	eorge's		Hvat	tsvi	11e							1 ☐ Yes 24] No
	r 282	Funeral Director	10e. Street and Number				10f. Zij	Code				10g. Citi.	zen of Wha	at Country	y?	
	th wit	alD	8514 14th Avenu	е				2078:	3			USA				
	r dea	ne	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Dece	dent of Hi	spanic Oriç n, Mexican	gin? (Specif , Puerto Rid	y Yes or No- an, etc.)		14. Race - A	American White, etc		
36	or it	by Fu	1 □ Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give	Мо		1 ☐ Yes		Specify:				Specify:			
21215-0036	hours tural' al Ex	q p	3 Widowed 4 Divorced	Year or Dates:		16a. Dece	dont'e Heu	al Occupa	ation			16h Vi	nd of Busin	oso/Indu	ote.	
15	in 72 1 "na" ledic	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of wo	ork done d	luring most }	t of working		TOD. KI	na or busin	ess/mau	stry	
12	with iene. thar	E	Elementary/Secondary (0-12)	College (1-4or 5	+)		macy					Med	ical			
	il Hygi other ent, tl	e C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name <i>(F</i>	irst, Middle,	Maiden	Surname)			
<u>la</u> r	lould be f Mental H narked of natic evel	To Be	Jacobus Dmytrysy	zn					Eup	phrsir	nia St	efan	kiw			
Mar	and sm		19a Informant's Name/Relationship (Route Numbe					
re,	os 1 and 2 of Health Item 27 I		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Na	me of other plac	e) :	Date		20c. Lo	cation - Cit	y or Tow	n, State	
E	Pages nent of I int: If Its iny or o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		l.		-	,	netery		1. 4,	Sil	ver S	prin	g,Mary	land
Baltimore,	permit. Pages Department of Important: If It any injury or once.		21. Signature of Funeral Service Licen	see		22 F	2. Name a	nd Addres	s of Facility	lins E	Tunera				, MD 20	
	Physician /Medical		23a. Part1. Exter the disease, or com shock, wheart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin a. Brain Tu	mor	Do not ent								A	Approximate nterval Between Onset and Deat	n
3,092	te be executed ysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last	b. Arrhythm Due to (or as a	nia a consequer	nce of):										
.O. Box (The law requires that the death certifica tee has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	⊒Ectopic p ⊒Other (s					2	23d. Date o Month	,	ay Year	
σ,	s that ned b e deta	by Pi	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ng in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	se contribu	ite to the	cause of death	1?
Records,	quires an sign uld be	g p	Osteoarthritis, F	ailure To	Thriv	e, Co	lon	Cance	er		1 🗆 `	Yes 🍇	□ No 3[☐ Probab	oly 4 □Unkn	iown
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Ä	The lav	E O		-								rmed?	dea	or to comp th?]Yes 2	oletion of cause	ı of
		Be	25. Was case referred to medical						26. Place	of Death (C	1□ Yes Check only o	2 No	<u> </u>	res 2	. □ 140	
>	di S	To B	examiner? 1 ☐ Yes 2 € No	Hospital: 1 ☐ Inpatie	nt 2 EF	R/Outpatier	nt 3 □ D	OA Othe	or:		5 ☐ Resid		6 □Other	(Specify)	-	
	ding Ph		27. Manner of Death	28a. Date of Injur	ry 2	8b. Time o Injury	f .	28c. Injun Work			d. Describe I			(//		
Ö	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		, , , ,	n qui y	M		ves 2 □1	No						
5	al or Attend s after death.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ury - At home c. (Specify)	e, farm, str	eet, factor	y, office		28f	. Location (S City or Tox	Street an wn, State	d Number (or Rural I	Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifler (Check only one)	ysician: To the best on niner: On the basis of and manner sta	f examinatio	edge, deat n and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, and th occurred	d due to the at the time,	cause(s)	and mann d place, and	er as stated due to t	ted. he cause(s)	
	To the To the Comp.	M	29b. Signature and title of certifier	() P	0 .		29	c. License		^		29d. Dat	te signed (/	Month, D	ay, Year)	
	8		Jaman 30. Name and address of person who	f- (h	eath (Item ?	Sa) /Tuna	Print)	219	609	1			Dece	mber	30, 20	009
			Raman Tuli, MD	3503 Pe	rry A	venue		. Rai	nier,	, MD 2	0712					
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signatur	re de	. 10.1	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician SU-CHIH CHAD CHEN 1305 PM DEC 30 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LORIEN COLUMBIA COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ ME Yrs Director 80 214-94-7957 Sept 30, 1929 Taiwan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Markins. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6397 Lookinglass Lane 21045 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: Asian 3 ₩idowed 4 Divorced Completed I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Huan - Hsin Chao Huang Ho 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Lord/ son-in-law 6397 Lookinglass Lane Columbia, Maryland 21045 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Journey Crematory 1/4/2010 Woodbine, Maryl 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Woodbine, Maryland 21. Signature of Funeral Service Lice Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ysician renal End nunths Stage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hyperten Sa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After to d in by the funera Certification: the Hospital or Attending nin 24 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month,

MD, FCCP

Year)

JAN 0 5 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1

Colym

32. Røgistrar's Signature

29c. License number

036845

29d. Date signed (Month, Day, Year)

haugen, MD, FCCP

Dec. 30, 2009

			1 - State of Maryland / De Registrar	partment of Health and ertificate of Death		giene Reg. No. 2009 43308
ı	Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year
	/Medic		John Edwin Conn 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		oer 29, 2009 7:13 A ^M 4c. County of Death
			Garrett County Memorial Hospital	0akland		Garrett
	Funeral Director		5. Social Security Number 377-12-3564 6. Sex 1X M 2 F 7. Age (In yrs. last birthda yrs. last birth	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir	n. (Month, Day	9. Birthplace (State or Foreign Country)
	Б		Usual Residence of Decedent		Nov. 21	, 1922 Maryland
	larylar show	ğ	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 [XYes 2 □ No
	the N	Director	MD Garrett Kitzmil 10e. Street and Number	1er	1	10g. Citizen of What Country?
	th with		266 W. Main Street	21538		United States
9	I within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Exata her i ust be redified at	y Funeral	1 Never Married 2 Married 1 Yes 2 No	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ XNo Specify:	(Specify Yes or No- erto Rican, etc.)	Black, White, etc.
5-0036	hours fural",	ed by	3X Widowed 4 L. Divorced Year or Dates:	cedent's Usual Occupation		Specify: White
¢121	vithin 72 ne. han "na e Medic	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of w . DO NOT use retired)	orking	16b. Kind of Business/Industry
7	int,	ပိ	8 17. Father's Name (First, Middle, Last)	aborer	ame (First, Middle, i	City of Baltimore
land	Ald be Alental rked o	To Be	(unknown)	(unkno	, , , .	narion dantano,
Mary	2 should be and Mentalls marked of raumatic ev		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or F	Rural Route Number	r, City or Town, State, Zip Code)
e, e	1 and Health em 27 em 27		Louise Hardesty, Step-daughter 122 20a. Method of Disposition 20b. Place of Dis			, MD 21538 20c. Location - City or Town, State
aitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of ematory or other place) n Cemetery 12/	31/2009	, , , , , ,
a	permit. I Departm Importal any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	-	Mt. Zion, MD
מ	e a m e e	2 1	Kotherine Sweitzer	David A. Burdoc 710 Church St.,	k Funeral Kitzmill	Home, P.A. er, MD 21538
		8 13	23a. Part1. Enter the disease, or complications that caused the death. Do not on shock, or heart failure. List only one cause on each line. Immediate Cause (Final		1 /	rest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	une Cucyling	20100	year (
	Examiner			HBP		yezrs
	nsit	Examiner	Sequentially list conditions, if a ry, leading to minimum the cause. Enter Underlying Cause, (Disease or injury)			
5	fficate be executed g physician and s the burial-transit	Exa	that initiated events c			
00/00	cate be physici the bu	edical	d		-	
י מ מ	nding puse as	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ā ;	Hooping or Attending Prystolan: The law requires that the death certificate be executed 4 hours death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	Ctopic pregnancy Cother (specify)		Month Day Year
	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to the cause of death?
cords,	equires en sig ould be	ed by			. 1 □ Ye	es 2 ☐ No 3 ☐ Probably 4X Unknown
בַּ	e 2 sho	Completed			24a. Was a	by prior to completion of cause of
ם י	n: The fficate or, pag		OF Western death and the			med? death? 2 ŒNo 1 □ Yes 2 □ No
5	ysicia is cert directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 X ER/Outpat	Other:	eath (Check only on	ence 6 ☐ Other (Specify)
) = }	Attending Physician: The law ar death. ector: After this certificate has by the funeral director, page 2 by		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at		ow injury occurred
<u>ו</u>	death.	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of Injury. At home form	M 1 ☐ Yes 2 ☐ No	20f Looption (Or	D 10 1 1 1
2	s after s after af Direct	Certif	4 Homicide determined building, etc. (Specify)	meet, lactory, office	City or Town	treet and Number or Rural Route Number, n, State)
1000	lo the Hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 ⚠ Certifying Physician: To the best of my knowledge, de 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the courred at the time, d	cause(s) and manner as stated. late and place, and due to the cause(s)
į.	vithin 2 To the I	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
			1	D15333		12/30/09
		3	30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Thomas G. Johnson, 311 N. 4th		MT) 21550	
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Jan Mariana, I	טכנוג עוי	
	Registra	ar	MAN - 4 2010 Ab A. A.	100		

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:45 a^M **Physician** December 2009 Mary Jane Costley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Winfield ar 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Carroll Brinton Woods Nursing Home 5. Social Security Number | 6. Sex | 7. Age (h Birthplace (State or Foreign Country) If Unde 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F Yrs. Maryland May 25, 1939 Director 213-38-6795 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director 28a-f Westminster Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number ŏ USA 23a 21157 Funeral 63 Charles St. 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? "natural", or items 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or itee 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sam Shoemaker Alcohol & Drug Counselor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Mae Cook ပ Joseph Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21158 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr MD Westminster, 723 Young Way Sheila Gibson - Daughter altimore, 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster, Maryland 12/22/2009 Ellsworth Cemetery 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA of Funeral Service License 412 Washington Rd. Westminster, MD 21157 23a. Part of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) March **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter the control of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 ☑No ed by the a 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 1No 1 ☐ Yes 2 17No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 1 F Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, nours after death. neral Director: Af filled in by the fur 124 hours a within 24 hor To the Fune completely fi To the I WJL

> State Registrar

Medical

HTRICK 31. Date filed (Month, Day, Year)

Till Osas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

3 ☐ Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifie

32. Registrar's Signature A. Sark

54178 102

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	1 - For State Registrar	State of W	-	Certificate of D		, 0	eg. No.		
	Physicia	un/	1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	200	3. Time of Death	
	Medic		Maude Calla					Decembe	er 23 20	509 6:40 %	
	Examir	ier	4a. Facility Name (if not institution, Anne Arunde1		an + a w	4b. City, Town, or			4c. County of D		
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birtho	Annapol	L 1 S _If Under 24 Hrs.	8. Date of Birth	Anne Ai	Birthplace (State or Foreign	
Ę	Director		579-40-9715 Usual Residence of Decedent	1 □ M 2NDXF		rs. Months Days	Hours Min.	ug. 19	Year) i	Country) eorgia	
	yland -f show ed at	ctor	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
:	r 28a notifi	Dire	Maryland Anne	Arundel_	Annap	01is 10f. Zip Code				MXYes 2 □ No	
:	with the 23a of st be	Funeral Director	1138 Bay Hic	chianda Da	- 4	·	100	10	Og. Citizen of What		
:	leath tems er mu	Fun	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of His If Yes, specify Cuban		cify Yes or No-	14. Race - A	merican Indian,	
21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 Never Married 2 Married 1 Yes 2 1 No If Yes, Give Year or Dates. 15. Decedent's Education (Specify nolly highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working 16b. Kind of Busing D. C. Developed 12+b 7 Vrs Social Morkor Family									
-5	72 ho n "nat fedica	nple	(Specify only highe	t's Education st grade completed)	((Decedent's Usual Occupa Give kind of work done du	tion uring most of worki		16b. Kind of Busine D.C. Deγ		
75	vithin jene. or thai	Con	Elementary/Seconday (0-12) 12th	College (1-4 or 5	D+)	fe. DO NOT use retired) Social Wor	rker		_	Services	
ي ع	filed v al Hyg i othe vent,	Be	17. Father's Name (First, Middle, L	ast)	J.		18. Mother's Name	(First, Middle, Ma	aiden Surname)		
<u>ya</u>	ld be Menta arkec atic e	မ	Henry Harr	is			Mau	de Ric	nards		
Maryland	shou n and 7 is m raum		19a. Informant's Name/Relationsh		447	Mailing Address (Street ar	nd Number or Rura	Route Number, C	City or Town, State,	Zip Code)	
9	and 2 Health tem 2 ther 1		Angela Callah 20a. Method of Disposition	<u>ian (Daugh</u> i		14 Cresthi					
Baltimore,	Page 1 ment of tant: If it lury or o		XX Burial 2 Cremation 4 Donation 5 Other (S)		cemetery.	crematory or other place te Mem. Ga	rdens 1	2/28/09		polis, Md.	
Balt	permit, Depart Import any inj once.		21. Signature of Funeral Service Li	censee Ress McC4	83	22. Name and Address Wm. Reese				apolis,MD. A. 21401	
			23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that caused	the death. Do not	enter the mode of dying	, such as cardiac o	r respiratory arrest	t,	Approximate Interval Between	
P	nysician/		Immediate Cause (Final disease or condition	Anoix	Encepal	operthy				Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a	a consequence of)	1 1 7	Failwe				
		Jer	Sequentially list conditions, if a y, leading to miniculations. Enter Underlying	b. Cows	consegnation of	HEAVET	allowa				
To the	ansit	Examiner	Cause (Disease or iinjury	_	,						
0	physician and the burial-transit	EX	that initiated events resulting in death) Last	Due to (or as a	a consequence of)						
8760 Finale be	hysici the bu	Nedical	'	d							
687	E & B	-	IF FEMALE:	23c. If yes, outcome	of pregnancy						
Box	requires that the death certific been signed by the attending should be detached for use as	Completed by Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 4 Pregnant at	2 🔲 Fetal death	3			23d. Date of a	delivery Day Year	
P.O.	led by detac	y Ph	Part II. Other significant condition				n in Part I.	23e. Did toba	acco use contribute	to the cause of death?	
dS,	an sign	ed b	End Stage	Renal D	Seasl			1 🗆 Yes	2 No 3 🗆	Probably 4 🗆 Unknown	
Records,	nas ber e 2 sho	nplet	0					24a. Was an autopsy	prior t	autopsy findings available o completion of cause of	
								performe 1 Yes 2		? /es 2 \(\subseteq \text{No} \)	
Ital	is certific	8	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	1	Other	ce of Death (Check	only one)			
ISION Of Vital	eral di	e: 10	27. Mann of Death	28a. Date of injur		atient 3 LI DOA	4 ☐ Nursing Hor	ne 5 Residen 8d. Describe how	ce 6 Other (Sp.	ecify)	
ס"ו קייו קייו	ath. rr: Afte	ficat	1 Natural 5 Pending 2 Accident Investig	ation	; Year) inju		es 2 🗆 No		,,		
Division of Vital	within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral di	Certificate:	3 Suicide 6 Could n 4 Homicide determin			, street, factory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,	
Cospita	hours hours and filled	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occured at the time, o	date and place, and	due to the cause	(s) and manner as	stated.	
H ed	hin 24	Mec	only one) 3 L. Certifying	Nurse Practioner: To the t	camination and/or in sest of my knowled	nvestigation, in my opinion ge, death occurred at the	, death occurred at time, date and place	the time, date and , and due to the ca	place, and due to th ause(s) and manner	e cause(s) and manner stated. as stated.	
P	2 1 2 S		29b. Signature and title of certifier			29c. License r			d. Date signed (Mor	nth, Day, Year)	
		4	OO Name and add to the				058297		12/23/	2004	
(1)	45		30. Name and address of person w	INY MO	anne A	orundel M	edical C	enter	Annapl	is MD ZIYO	
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	2009 32. Rigistra	r's Signature	barker			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D28, 2009 **Physician** December Phyllis Allen Donnelly 3:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🛣 F Months Days Hours 213-44-3514 64 Director Oct. 6, 1945 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinator is used to reinfied at aging injury or other traumatic event, the Medical Examinator is used to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 □Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 82 Great Lake Drive 21403 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2/CXNo Specify. þ Specify: White 3 Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Quality Assurance Supervisor State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis V. Allen Inez Lee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Donnelly, III/son 82 Great Lake Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 12/31/2009 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home Myelin T. Wolet 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** contributional temorrhage week /Medical Due to (or as a consequence of): **Examiner** Weeks Intra cran sal hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a scheequence of): Exami Bladder concer with Metastatic disease, to liver Due to (or as a consequence of): Physician/Medical abdominal cavity 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

Donnelly, Phyllis

State Registrar

burial-transit

attending physician for use as the buria

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signed by t

After this certificate has been s funeral director, page 2 should

the 1

filled in by

completely

as

and

Box 68760,

P.0.

Karen M. Lynn Piper MD 31. Date filed (Month, Day, Year)

DEC 30

29b. Signature and title of certifier

Yaumahmitpio m

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cenera B. parks

6701 N Charles St. Swite 5218

29c. License number

D47223

29d. Date signed (Month, Day, Year)

21204

12/28/2009

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#23a(c/d)perMD, 12/31/09, BMW, McQertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2009 6:45 PM FRANCES MICHAELA DEILY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Feb. 24, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF ^{Year)} 1948 Director 61 Pennsylvania 215-54-5957 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 🖺 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2100B Whittier Drive 21702 USA "natural", or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 2 X No 21215-0036 72 hours after Yes 1 Yes 2 X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates White is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 4 Administrative Assistant Federal Government Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francis Beamer Frances McClintock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison Wolbert/Daughter 12709 Hayes Road, Myersville, MD 21773 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State 2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner HOUL! Valory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Parkinsons Disease that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Diabetes Mellitus attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 X No 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 0006 2223

Registrar DHMH 17 Rev 7/2009

State

Box (

P.O.

Records,

Division of Vital

MD

196 TJ PRIVE FREDERICK

ss of person who pempleted cause of death (Item 23a) (Type, Print)

BOLARUM

RAYEGN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evelyn Frances Douglas 6:35 P M Dec. 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. . Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours New York 89 132-01-9323 Director June Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MD Anne Arundel Severna Park 1 Yes 2 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21146 35 Holly Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No any injury or other traumatic event, the Medical Examiner Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Yes, Give ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Anne Arundel County College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) l and 2 should be filed f Health and Mental H item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) William Van Buskirk Leona M. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald N. Douglas, Jr. Son 3520 Stansbury Mill Road Phoenix, MD 21131 Department of Hea Important; If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Date 4 cemetery, crematory or other place)
MD Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses Barrancodes Sons. Barrantod & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ -nterst disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Part I<u>I.</u> Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) f Death 27. Mann Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one D00058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Centr Anna Anne Arunde MO only 1. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 422 Schoolers Pond Way Arnold If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 №M 2 □ F Country)
New York (Month, Day, Ye Vear 72 Director 074-30-4638 1937 Nov Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis MD 1 ☐ Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1254 Destiny Circle 21409 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1955 Black, White, etc. 1 Never Married 2 Married X Yes Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ⅓ Widowed 4 ☐ Divorced 1958 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Regional Vice President Voque Tyre Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Dunn Vera Soimos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Schoolers Pond Way Arnold, MD 21012 Michael J. Dunn / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cemetery 2009 Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 495 Gov. Ritchie Hwy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate outce. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signated bage 2 should b Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 Dother (Specify) SON'S HOME မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 28c. Injury at work?
1 Yes 2 No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation Suicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December [™]22, 2009 10:44P M Valerie DeAngelis Lynn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u> Anne Arundel Medical Center</u> Anne Arundel Annapolis If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/11/1948 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1□ M 2 🖵 F Months 220-50-5533 61 Yrs Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examiner must be redified at 28a-f shov Maryland Anne Arundel Arnold Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 25 Chautaugua Road 21012 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Motical Examine once. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> Vice President</u> DeAngelis & Son, Inc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald W. Doke Jeanne C. Landis ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. DeAngelis - Husband 25 Chautaugua Rd, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) : 12/28/2009 | Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Inc Myslin I 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Caucer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events are the cause of t Examine Due to (or as a consequence of): Physician; The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. signed by the a 1 □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

acked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stand Bell MD 2001 Medical Parkway anna polis, MD

Registrar's Signature

bud Bech MD

DEC 28 2009

31. Date filed (Month, Day, Year)

0

12/23/09

			For	State of Ma	aryland / De	epartment of	Health and M	ental Hyg	jiene	
			State Registrar		(Certificate of	Death	R	leg. No 2 0 0 1	9 43317
	L 4.		1. Decedent's Name (First, Middle	le, Last)				2. Date of Dea Month	th Day Yea	3. Time of Death
	Physici /Medic		Muriel A. Dav	ies				ecember		
140	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town,	or Location of Death		4c. County of De	eath
-			Deborahs Assist	ted Living		Derwoo			Montgome	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth	Months Days		8. Date of Birth (Month, Day 11/19/1	Year) 9. E	Birthplace (State or Foreign Country) England
	Director		213-42-6502 Usual Residence of Decedent		103 Y	S.		11/19/1	.906	England
	and		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary f she	호	Maryland Fred	erick	Mt. Air	cv				1 ☐ Yes 2 📉 No
	the 1	rec	10e. Street and Number		1100 1111	10f. Zip Code			0g. Citizen of What	Country?
	3a ol	D E	5400 Sidney R	oad		21771			USA	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, Ite Medicel Exemit or mart be rivillied at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Spe	cify Yes or No-	14. Race - A	merican Indian,
9	after or ite	교	1 ☐ Never Married 2 ☐ Mar	Armed Forces? ried 1 ☐ Yes 2 ☑ I	No	1 ☐ Yes, specify Cu	ban, Mexican, Puerto I	Hican, etc.)	Black, Wi	
21215-0036	ral",	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TILITES ZAN	Specify:		Specify: W	Mhite
5-(72 h 'natu	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	1 (ecedent's Usual Occi Give kind of work don	e during most of working	ng I	16b. Kind of Busine	ss/Industry
121	/ithin ne. han'	귵	Elementary/Secondary (0-12)	College (1-4or 5	i+)	ife. DO NOT use retir	ed)		G1 1-	
	led w Hygie her t	ပိ	17. Father's Name (First, Middle,	4	Re	ligious E	18. Mother's Name	/Eiret Middle	Church	
anc	ould be fi Mental ⊁ arked ot atic ever	Be	Thomas Hannah	Last)			Lillian	Lowe	waiden Sumame)	
ž	should I and Men marke	ဥ	19a. Informant's Name/Relations	hin (Time Brint)	10h 8	Aniling Address (Ctra	et and Number or Rura		r City or Town State	a. Zin Coda)
Maryland	d 2 s Ith an 17 Is trau		Leslie L. Coler		I					771
	1 and Health tem 27		20a. Method of Disposition	nan granada	20b. Place of D	isposition (Name of	, D	ate Ita	20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examination in the best office and once.		1 ☐ Burial 2 🖺 Cremation		cemetery,	crematory or other pl litan Crei		23/09	Alexandri	a VA
#	nit. F artme ortan Injur e.		4 □ Donation 5 □ Other (S 21. Signature of Pureral Service		J. J. J. J. J. J. J. J. J. J. J. J. J. J		ress of Facility Adv	· .		
B	permit. Departi Importi any Inji			auce			Hwy. Falls			
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final	only one cause on each lif						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to or as	a consequence of					aweets.
	Examiner			Too	0	to the	ive.			
	7	ner	Sequentially list conditions,	Due to (or as	a consequence of					
	ransi	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	с						
ó,	e exe ian a urial-1	Ä	resulting in death) Last	Due to (or as	a consequence of	:				
68760,	icate be executed physician and the burial-transit	dical		d						
_	ertific ling p	Mec	IF FEMALE:							
Box	eath certifi attending I for use as	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 🗆 Ectopic pregna			23d. Date of Month	delivery Day Year
0	at the dea by the a tached for	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify)			Monar	Day Tour
σ.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as		Part II. Other significant condition	ons contributing to death b	ut not resulting in t	he underlying cause o	iven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Records,	signed I	t by			-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 □ Y	es 2 No 3	Probably 4 ☐ Unknown
Ö	w requir been s should	ete					-	04- 14		autonau findinas ausiloblo
Rec	has has	Completed						24a. Was a autop: perfor	sv prior	autopsy findings available to completion of cause of
<u>a</u>	ian: The l rtificate hator, page		05 111					1 ☐ Yes	24□M6 1□Y	es 2 Ne
Vital	sician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:			26. Place of Death			11
of	g Physical this leral di	1: To	1 ☐ Yes 2 ☐ Mo	1 ☐ Inpatre	ent 2 ER/Outp	atient 3 DOA	4 L Nursing Hor		ence 6, Other (Something of the common of th	Specify) HOSPICE
Division	iding th. After funer	ţio	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	g (Month, Da		ıry Wi	orḱ? ⊡Yes 2.⊡No		,,	•
/isi	I or Attend after death. Director: #	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Inju	ury - At home, farn	n, street, factory, office		28f. Location (S	treet and Number or	Rural Route Number,
ă	- 9 2 -		4 ☐ Homicide determ	building, etc	c. (Specify)			City or Tow	n, State)	
	al or A s after Il Direct	èrt		-						
	ospital o hours aff uneral Di	sal Certification:		ng Physician: To the best						
	the Hospital or Attending iin 24 hours after death. the Funeral Director: After ppletely filled in by the fune			-	f examination and					
	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in E	Medical Cert	(Check only 2 Medical	ng Physician: To the best Examiner: On the basis o and manner sta	f examination and	or investigation, in my	opinion, death occurr	ed at the time, o		due to the cause(s)
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in		(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis o and manner sta	f examination and	or investigation, in my	opinion, death occurr	ed at the time, o	date and place, and o	due to the cause(s)
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in		(Check only 2 ☐ Medical one) 29b. Signature and title of certifie	ng Physician: To the best Examiner: On the basis of and manner start	f examination and	or investigation, in my 29c. Lices	opinion, death occurr nse number 0 576 8 8	ed at the time, o	29d. Date signed (Ma	onth, Day, Year)
	To the within 2 To the comple	Medical	(Check only 2 ☐ Medical one) 29b. Signature and title of certifie	ng Physician: To the best Examiner: On the basis of and manner start	f examination and	or investigation, in my 29c. Lices	opinion, death occurr nse number 0 576 8 8	ed at the time, o	29d. Date signed (Ma	onth, Day, Year)
0	To the Hospital of within 24 hours aff within 24 hours aff To the Funeral Discompletely filled in the first filled in the	Medical	(Check only 2 ☐ Medical one) 29b. Signature and title of certifie	ng Physician: To the best Examiner: On the basis of and manner start	f examination and	or investigation, in my 29c. Lices	opinion, death occurr nse number 0 576 8 8	ed at the time, o	29d. Date signed (Ma	onth, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24, 2009 Columbus December 10:20 a.M **Ulvsses** Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Tacoma Park Prince George's 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Date of bill (Month, Day, Ye h 29 **Funeral** 1 X M 2 □ F Months Days Hours Year Country) Virginia 59 **Director** 229-66-7186 March Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Prince George's Maryland Bowie 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12710 Hoven Lane 20716 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or \$ 1 Never Married 2 X Married Maryland 21215-0036 African If Yes, Give Year or Dates. 1969–84 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced Americar injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other ti Republic Foods Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Claude Davis, Sr. Lillie Mae Tv1er 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i Patricia A. Davis/Wife 12710 Hoven Lane, Bowie, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of h
Important: If ite
any injury or oth cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/28/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 1-AILURE Physician/ 4381RA 70RY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NEUMONIA securi Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit THE DIDA Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-KIDNEY Physician/Medical STAGE CHRONIC Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ည ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 0 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor 7600 CANLOU AKOMA KANDAU LIKENSON MID. DEC 30

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 31, 2009 Phyllis Ruth Ercoli /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Briarmeadow Derwood Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 7 F Nov 14, 1924 Director 85 193-16-6731 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 28a-f show or other traumatic event, the Wedical Exercitar stust by notified at Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 9900 Georgia Avenue #106 20902 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐Yes 2 🙀 No Specify 2 Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) 12 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental William Snyder Mabel Kingman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Linda Krimstein/daughter 81507 Castlerock Court La Quinta, California 92253 Department of Healt Important: If Item 2 any Injury or other once. 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 1/6/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service Beverly L. Heckrotte, P.A. 21. Signature of Funeral Service Lic P.O. Box 784 Clarksville, MD 21029 M01251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart before. List only one cause on each line. Immediate Cause (Final **Physician** BREAKT CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed the burial-transi ding physician and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 🔀 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 □Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

Montgomery

Birthplace (State or Foreign Country)

Pennsylvania

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2 No

10:38a [™]

within 24 hours after To the Funeral Dire 4

State Registrar For State Registrar

DHMH 17 Rev 1/2001

To the Funeral Director: After this certific completely filled in by the funeral director,

Be

Certification: To

Medical

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 □ Natural 2 □ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2010

WONG, M.I

5 Pending investigation

6 □ Could not be

28a. Date of Injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ROCKVILLE

32. Registrar's Signature

RECORD

28b. Time of

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of a minute and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Other: 4 Nursing Home 5 Residence 6 Pether (Specify) Group Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2009 Month **Physician** December P^{M} Helen Marie Edgar 2:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Frostburg Allegany If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**K** F 68 Maryland Director July 1, 1941 218-38-2401 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 X No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11914 National Pike 21536 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 s 1 and 2 should be filed w if Health and Mental Hygiel item 27 is marked other tt Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Garlitz Rose Garlets 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Joseph J. Edgar/Son 227 Nah Stadt Acres Dr., Salisbury, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cemetery Dec. 31, 2009 Grantsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 elma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse juence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. ned by the 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 Hellow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 925 Bishop Walsh Rd., Cumberland, MD Harjit Sidhu, 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month **Physician** Baby Girl Erter December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month/Day,/Year) **Funeral** Days Hours 1 M 2 F Yrs. 12/8/2009 Director infant Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If to Madical Evantines must be notified at any Injury or other traumatic event, If to Madical Evantines must be notified at any once. 10a. State 10b. County 10c. City, Town or Location MD Baltimore Phoenix Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14 Glen Alpine Road Funeral 21131 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2MNo Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) infant Elementary/Secondary (0-12) infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Monalee Erter Aaron Erter ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 N. Charles Street Baltimore, MD Greater Baltimroe Medical Ctr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from Stat 4 ☐ Donation 5 🖾 Other (Specify) in state Signature of Juneral Services State Anatomy Board 655 W. Baltimore Street MD 21201 timore,

Physician

Division of Vital Records, P.O. Box 68760,

Examiner		Tooding in death)		Due to (or as a conseq	juence (
	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.	Due to (or as a conseq	
Hospital or Attending Physician: The law requires that the death certificate be executed Fuh brours after death. Puneral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit	d by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions of		c. If yes, outcome of pregnance of Live birth 2 Feta 4 Pregnant at time of a Unknown	al death death
ysiclan : The law requis certificate has been director, page 2 shoul	To Be Completed	25. Was case referred to medical examiner? 1	Но	spital: 1 ☑ Inpatient 2 □	l ER/Ou
Hospital or Attending Ph. 24 hours after death. Funeral Director: After thistely filled in by the funeral of	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	е	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h building, etc. (Specia	28b. 7
Hospital 24 hours: Funeral stely filled	dical Ce	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	nysl	cian: To the best of my kno er: On the basis of examina	wledge ation an

Immediate Cause (Final disease or condition

nt at time of death 5 Other (specify) vn 23e. Did tobacco use contribute to the cause of death? th but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy 1 ☐ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

23d. Date of delivery

Month

Other: 4 Nursing Home 5 Residence 6 Other (Specify) atient 2 ER/Outpatient 3 DOA Injury Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐Yes 2 ☐ No

Injury - At home, farm, street, factory, office, etc. (Specify)

23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.

as a consequence of)

as a consequence of):

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Day

8

4c. County of Death

<u>USA</u>

Specify.

infant

Race - American Indian, Black, White, etc.

Year

2009

<u>Baltimore</u>

9:

Birthplace (State or Foreign Country)

indian

MARYLANC

10d. Inside City Limits

1 ☐ Yes 21 No

est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) r stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles St. Baltimore, MD 21204 Hsiao-Hui Lin, M.D.,

State Registrar 31. Date filed (Month, Day, Year)

within To the compl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EN 2009

4b. City, Town, or Location of Death

4c. County of Death

Funeral Director

Physician

/Medical

Examiner

1 - For State Registrar

4a. Facility Name (# not institution, give street and number)

MARYLAND MED

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evancher in ust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	5. Social Security Number	er 6.	Sex	7. Age (In yrs.	last birthday)	If Unde		If Under		8. Date of B	irth	-)	9. Bir	thplace (State or Foreign
	214-78-523	8	1 X M 2 □ F	47	Yrs.	Months	Days	Hours	Min.	June 2	6, 1	962	Măi	ryland
	Usual Residence of Dec	edent						1						
	10a. State 10b	. County		10c. City	y, Town or Lo	ocation								10d. Inside City Limits
ō				1 .	. 1									1 t Yes 2 □ No
ect	MD				Baltim	_								21
ä	10e. Street and Number					10f. Zip	Code				10g. C	itizen of V		ountry?
ā	2601 Madi	son Av	venue #2	04				2121	7			US	A	
le l	11. Marital Status		12. Was Dec	edent Ever in U.	S. 13.	Was Dece	dent of H	ispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	0-			erican Indian,
교	1 ✓ Never Married	2 Married	Armed Fo	2X No				in, Mexica	n, Puerto	Hican, etc.)		Blac	k, White	
Ď	3 ☐ Widowed 4 ☐		If Yes, G Year or D	ive Dates:		1 □Yes	2 X No	Specify	:			Specify	: D	lack
ed	15	Decedent's I	Education		16a Dece	edent's Usu	al Occur	ation			16b	Kind of Bu	isiness/	Industry
Set	(Specify or	nly highest g	rade completed)		(Give	kind of wo DO NOT u	rk done	during mos	st of work	ing	1001		2011/0001	
Be Completed by Funeral Director	Elementary/Secondary	y (0-12)	College (1-4or 5+)	mc.	201101 4	oc remot	′/				ma	arke	t
Se C	17. Father's Name (First,	, Middle, Las	st)					18. Moth	er's Name	(First, Middle	e, Maide	n Surnam	ie)	
2	Jerry Elli	is Sr							G	enova I	E11e:	n _		
	19a. Informant's Name/F	Relationship	(Type. Print)		19b. Maili	ng Address	S (Street	and Numb	er or Run	al Route Num	ber, City	or Town,	State, 2	Zip Code)
П	Jerry Elle	en Sr/	dather		110	00 Per	ansv.	lvani	a AV	enue #1	1214	Ba1t	imo	re, MD 21201
	20a. Method of Disposition			20h P						Date				Town, State
	1 ☐ Burial 2 ☐ Cre	emation 3 l	Removal from	SIGNE	lace of Dispo emetery, crei	matory or c	ther plac	e)		Jui 0	200.	200411011	O., 01	Town, olato
	4 ☐ Donation 5 🗓	Other (Spec	oify) in st	ate				i						
	21. Signa Lie - Funeral	Service Lice	ensee	Mecton	. 2	2. Name ar	Addre	ss of Facili	ty Coord	655 T.	ъ.	1		0+
	som	1/1/	1771		B	altim	ore,	MD 1	2120	1 055 W	• ва	T C III	ore	Street
	23a. Part Enter the dis	sease, or ob	mplications that	caused the death	n. Do not en	ter the mod	de of dyir	ig, such as	cardiac	or respiratory	arrest,			Approximate Interval Between
	shock, or heart fail Immediate Cause (Final		y one cause on e		1.161	CAT	7//	75						Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. ACUTE LINEL FATUURE													
H	Due to (or as a consequence of):													
احا	Sequentially list conditions, b. LACTIC ACIDOSIS													
ne	Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events c.													
am	Cause (Disease or injury that initiated events		C.											
ШĂ	resulting in death) Last	1	Due to	(or as a consequ	ience of):									
cal		•	d											
g														
ξ	IF FEMALE:		23c. If ves. ou	tcome of pregna	ncv							OOM Doe	o of do	li
ä	23b. Was decedent preg in the past 12 mont		1 🗆 Live	birth 2 Fetal	death 3	Ectopic p						23d. Dat Mo		Day Year
Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 □ Preg 9 □ Unkr	nant at time of d	eath 5 L	Other (s	pecify) _							,
Be Completed by Physician/Medical Examiner														
2	Part II. Other significant	t conditions	contributing to d	eath but n ot resu	ilting in the u	inderlying o	ause give	en in Part	1.					the cause of death?
pa	HJU									1 🗆	Yes	2 □ No	3 □ P	robably 4 Unknown
let	HEPATITI	SC								24a, Was	s an	24b. \	Nere au	utopsy findings available
m m					-					auto	ormed?	, F		completion of cause of
ၓ	DIABETE									1 XYes	2 🗆 N	0 1	1 □Yes	2 No
	25. Was case referred to examiner?	medical	Hospital:	,			Oth		e of Deatl	(Check only	one)			
2	1 Yes 2 No		1 1 X	Inpatient 2 🗆			DA Oth	ar: 4 □ N	ursing Ho	me 5 🗌 Res	sidence	6 □Oth	er (Spe	ecify)
ü	27. Manner of Death 1 Natural 5	Pending	28a. Date (Mon	of Injury th, Day, Year)	28b. Time o Injury	of 2	28c. Injur Worl	y at c?		28d. Describe	how inju	ury occurr	ed	
ä	2 Accident	investigation				M	1 🗆	Yes 2□	No					
iji	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not determined	28e. Place	of Injury - At ho	me, farm, str	eet, factory	y, office		2000	28f. Location	(Street a	nd Numb	er or R	ural Route Number,
èrt	- I romicide		Dulla	ing, etc. (Specif)	′/					City or To	wn, Sta	ie)		
2	29a. Certifier 1	Certifyina F	Physician: To the	e best of my know	wledge, deat	h occurred	at the fir	ne, date a	nd place	and due to th	e cause	s) and ma	anner a	s stated.
Medical Certification: To	(Check only 2 one)	Medical Exa	aminer: On the b	asis of examination	tion and/or in	vestigation	in my o	pinion, de	ath occur	red at the time	, date a	nd place,	and due	e to the cause(s)
Me	29b. Signature and title of	of certifier	-			290	c. Licens	e number		T	29d. D	ate signe	d (Mont	h, Day, Year)
		117					196					12/5	. ,	
	/	16					110	P				2/0	270	
	30. Name and address of		o completed caus	se of death (Item	23a) (Type,	Print)	1. 11		15 ~	C 400				KE MD 21221
	ALAN H. X	Farmer A					~ 4 /1C	^	11	1 -4 5 11.50	. /	971 /14"		

State Registrar

31. Date filed (Month, Day, Year)

JAN 15 2010

09-10075 Sarah Haley Foxwell

Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental Certificate of Death	pies Are Legible. Hygiene	009	43323
Name (First, Middle,Last)	2. Date of Death	3. Tir	ne of Death

,		1- For State Registrar	,	Certific	ate of L	Death			Re	∍g. No.		~ _	1001.
° Physici Medical Exami		Decedent's Name (First, Middle, Sarah Hale		.11					Date of Deat Month	Day	Year		3. Time of Death
Jweulcai Exami	nei	Sarah Hale 4a. Facility Name (if not institution,	-		I 4h	. City, Town,	or Location		December	25,	2009 c. County of [Death	1732 hrs
		32030 Melson Road	g.re en eet and namee	,		Delmar	or Location	or Death			Vicomico	Jeau	
Funeral			Sex 7. A	ge (In yrs. last bir	thday)	If Under 1 Y	_		8. Date of Bird	th(MM			hplace (State or
Director		212-53-0149	M 2 X _F	11	Yrs.	Months D	ays Hour	s Min.	05/18/	199		oreig	ryland
δ.		Usual Residence of Decedent 10a, State 10b, County		I40 00 T									
ow any			•	10c. City, Town									10d. Inside City Limits 1 Yes 2 X No
ryland a-f sh t once	ctor	Maryland Wicon 10e. Street and Number	nico	Sal:	isbury	7 10f. Zip Code				Oa Citi	izen of What	Cour	
or 28	Director	31453 Old Ocea	an City Roa	d		21804			"	_	JSA	Cour	u y r
with t		11. Marital Status	12. Was Deceden		13. Was [gin? (Spec	ify Yes or No-			Americ	can Indian, Black,
death rriten	Funeral	1 X Never Married 2 Marr	ied Armed Forces	? X No	If Yes	, specify Cub	an, Mexican	, Puerto Ri	ican, etc.)		White, e		
after	by F		ced If Yes, Give Year or Dates:			es 2X					Specify:	wh	ite
hours fratul	ted	15. Decedent's Education (Specific			Decedent's during most	Usual Occup t of working li	ation (Give fe. DO NOT	kind of wor	rk done d)	16b. l	Kind of Busin	ess/lr	ndustry
36 hin 72 e. than	ple	Elementary/Secondary (0-12)	College (1-4 or		tuden	t				l n	ı/a		
5-00 ed wit tygien other	Completed	17. Father's Name (First, Middle, La	ist)				18.Mother	's Name (F	irst, Middle, M		•		
1218 be fill mtal H rked	Be	Thomas Douglas	Foxwell II	I			Jen	nifer	Anne	Wec	hsler		
O 21 should and Me	2	19a. Informant's Name/Relationship Jennifer Foxwel		19					al Route Num				
, MI and 2: salth a	-	20a. Method of Disposition	.1/mother	20h Place		n (Name of c			Fruitl		Location - Cit		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men to F Reath and Mental Eygene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumante event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation	3 Removal from St	ate cremat	ory or other	place)	cinetery,					•	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 she injury or other traumatic event, the Medical Examiner must be notified at once	-	4 Donation 5 Other Spec 21. Signature of Funeral Service		Parso		netery	on of Familia		31/09	Sa	alisbu	ry,	MD
Ba perm Depa Impo injur		Kell R St	unes - (K	TP	22H0 50	l Toway L Snow	Funer Hill	al Ho Rd.,	ome Pro Salish	ofes	ssiona y, MD	1 <i>1</i> 218	Association 804
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause on	mplications that caused each line.	the death. Do no	ot enter the	mode of dyin	g, such as c	ardiac or re	espiratory arre	st, sho	ock, or heart		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a cons										Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of);									
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760, ficate be executed physician and the burial - transit	티		d										
O, e be ex-	Medical	UNPENDED	AMENDED									- 1	
8760, tificate be ng physici		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnancy 2	Fetal	death 3	Ectopic	pregnancy	v	230	d. Date of del Month	ivery Da	ay Year
Box 68's death certification attending	sician	past 12 months? 1 Yes 2 ✓ No 9 Unkno	4 Pregnant at	time of death 5		(Specify)		pregrame,	,	1			.,
. Bc he dea y the a	오		9 Unknown	- I- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					I as Tairi				
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by to led in by the funeral director, page 2 should be detached.	ρ	Part II. Other significant condition	s contributing to death	n but not resulting	in the unde	erlying cause	given in Pa	irt I.		_			ne cause of death?
ds, equire een sig	Completed				-				24a. Was a				opsy findings available
COF	齓								autops perform	у		to co	mpletion of cause of
ital Redician: The scertificate		25. Was case referred to medical				OC Plan	a of Dooth	(Ob 1 1	1 ✓ Yes 2	N	0 1 🗸	Yes	2 No
Vita ysician his cer directe	mັ∣	examiner?	Hospital: 1 Inpatie	nt 2 ER/Ou	itpatient 3		Other	Nursing H		Reside	nce 6 🗸 C)ther:	Scene
n of v	앍	27. Manner of Death	28a. Date of Inju	ry 28b. 1	ime of Injur	y 28c. Inj	ury at Work	? 28	d. Describe ho	ow inju	ıry occurred		
ion ttendi leath. tor: /	atio	Natural 5 Pending Accident Investig		1.00		1	Yes 2	No Su	ıbject assa	ulted	1		
ivisi lor Atr after d Direct	Certification:	3 Suicide 6 Could no	ot be 28e. Place of In	jury - At home, fa	rm, street, f	actory, office	building, etc	c. 28	f. Location (St or Town, Sta		nd Number o	r Rura	al Route Number, City
Di Hospital of 24 hours a Funeral I		4 Homicide determine 29a. Certifier	1000000						030 Melson	Road,			
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	G.	(Check only 1 Certifying Physone) 2 Medical Examin	er: On the best of m er: On the basis of examination and manner stated.	y knowledge, dea mination and/or ir	th occurred vestigation	at the time, on the street of	date and pla in, death occ	ce, and du curred at th	e to the cause e time, date a	e(s) and nd pla	d manner as ce, and due t	stated to the	d. cause(s)
0.	žΓ	29b. Signature and title of certifier				29c. Licen	se number			29d. E	Date signed	(Mont	h, Day, Year)
'AGN			VIII.			O.C	.M.E.			Dec	ember 26	, 200	9
OCME		30. Name and address of person wh			444 5	one Ct	4 D=14:	ora 140	24204				
Sta	to.		eputy Chief Medic	s Signature	back	enn Stree	u, baitimo	Jre, MD	21207				
Registi	ar	31. Date filed (Month Day Year) 20	10	الم مرهادة									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EISHMAN /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** Days Months Hours Min. Yrs. 579-50-1511 Director 89 10/10/1920 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla cartment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the "Marical Extra inter must be recitied at Director 1 ☐ Yes 2 X No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322 Charred Oak Ct. 21409 Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedon. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐ Yes 2**X**∭No Specify: \$ White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bernard Mary E. Reio 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harriet W. Bean/ Daughter 47822 Yaocomico Ln., St. Marys City, MD 20686 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Church Cem. 12/31/09 Forestville, MD 21. Signature of Funeral Sarfice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician s the burial Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery In the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: this Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Dother (Specify) After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.O. Division of Vital Records, Physician: or Attending

Maryland 21215-0036

Baltimore,

4 Homicide

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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TNNAPOUS

29c. License number 29th Date signed (Month, Day, Year)

29b. Signature and title of certile Name and address of person w completed cause of death (Item 23a) (Type, Print

State Registrar

31. Date fil-

NA W 32. Registrar's Signature

445

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles A. Foster State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea. No. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 30, Medical Examiner 1335 hrs Charles Foster 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6107 Bellona Avenue 2 C Baltimore 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Country) Months Director 218-01-6520 $1 \boxed{X} M 2 \boxed{F}$ 90 Yrs Apr 30. 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", mritems 23 mr 28s-f sho injury or ruther traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 6107 Bellona Avenue #2C 21212 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes 3 Widowed 4 X Divorced f Yes, Give Year 1 Yes 2 X No specify: white ₫ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 salesperson wholesale foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Linwood Foster Lola Elizabeth Hudgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carey Shenkel/daughter 4169 Norrisville Road White Hall, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify ²²State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, $_{\rm MD}$ t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): eause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transit The law requires that the death certificate be executed and Physician/Medical ned by the attending physician detached for use as the burial -UNPENDED **AMENDED** Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by ۵ 1 Yes 2 No 3 Probably 4 ✔ Unknown certificate has been sign rector, page 2 should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? _Yes 2 ✔ No Yes 2 No Hnspital nr Attending Physician: funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA After this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending r death. 1 Yes 2 No Director: filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined 29a. Certifier 1 completely Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. December 31, 2009 01 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day Year)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 Pearl V. 26:54M Gaines 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ninsula Realonal Wicomic Madia I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 X F Months Days Hours Min. (Month, Day, Year) Director 217-44-0822 10-194 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Salisbury Wicomico MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27510 Log Cabin 21801 Road
Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Il Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Seaford Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygie is marked other Industries permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ <u>William Gaines</u> Mary Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gaines/Son 1245 Lochwood Circle, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Free MC 4 Donation 5 Other (Specify) 2 - 201022. Name and Address of Facility 917 W. Lennie Smith Funeral Homenter the Isabella St. Salisbury. 23a. Part Let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of ysician and e burial-transit Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 nding physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 onknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 1 Tes မ 2 6100 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 3 Suicide 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Narse Praction within 2 To the To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

30. Name and address of Ferso

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 21 2009 **Physician** December 4:25 Louise Ellen Grimes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Ctr. 4b. City, Town, or Location of Death Examiner Carroll Lutheran Village Health Care Carroll Westminster If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 212 F Mar 04 1919 NC Director 216-05-2175 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b County items 23a or 28a-f show iner must be notified at 1 √Yes 2 No Carroll Westminster MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21158 USA 237 St. Mark Way Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Affiled Folces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No White Baltimore, Maryland 21215-0036 Specify: à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) L. Greif 11 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Pansy Letterman Doss Garland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 237 St. Mark Way Westminster, MD DiAnn Grimes Baum Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/28/09 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)
21. Six ture Funeral Series Lice Dulaney Valley Mem Gardens Timonium ,MD 2Protes Africally Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Due to or as a consequence of) /Medical **Examiner** Chrowne Clostorel Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine is or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2D No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 16 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the application. 29a. Certifier , in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MJL 12 30. Name and address of person who Sheruthene Sut 201, Westminster MIN Hereul 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 43328 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 10 SA PM 2009 Jean 2 20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Westminster, MD Carroll Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 72 Yrs. 91-32-459 06/30 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Westminster Maryland Carroll 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21157 1122 Lynn Haven Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedenl Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify: Specify: White 3 □ Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Jean Whitehair Burl James Delanev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3245 Main St. Manchester, MD Barbara Hamm Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 12/29/09 Garrison, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityPritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 23a. Papa. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Luke emmin Due to (or as a consequence of):

Physician /Medical Examiner

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of Health and Mantal Hygie If Item 27 is marked other to or other traumatic event, the

filed within 72 hours affer death with the Maryland

Saltimore, Maryland 21215-0036

rsician end e burial-fransit To the Hospitel or Attending Physician: The law requires that the death certificate be executed shys the been signed by the should be defached certificate has birector, page 2 s Affer thi funeral

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cudro Oue, to (or as a consequence) c. Due to (or as a consequence) d. Durbet	uence of):	ny		540 1540 1040
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3 Ectopic p			23d. Date of delivery Month Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ontributing to death but not res	ulting in the underlying o	cause given in Part I.	23e. Did tobac 1 Yes 24a. Was an autopsy performe 1 Yes 2 J	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 De	OA Other: 4 Nursing	Home 5 ☐ Residence	ce 6 ☐Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
27. Manner of Death Natural 5 Pending investigation	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factor	y, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my known iner: On the basis of examination and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier		29	c. License number	290	I. Date signed (Month, Day, Year)

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Registrar

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strar's Signature

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31. Date filed (Month, Day, Year)

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	Physic /Medi	cal	Ŀ	Boodent's Name (First, Middle, Last COSEVE + Facility Name (If not institution, give	1 Grav		n, or Location of Death	2. Date of Death Month 18 - 2	Day Year 17 - 2009 4c. County of Death	3. Time of Death
	Exami Funeral Director	ner	5.	Social Security Number 6. Sec	UVS ng Home A. Age (In yrs. last birth	£356	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Baltimo ar) 9. Birth	
	ne Maryland Be-f show difficulat	Director	10	Da. State 10b. County Baltim	10c. City, Town					10d. Inside City Limits 1∭ Yes 2 ☐ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Itema 23e or 28e-f show eurmetic event, the Wedleal Examirer must be recitifed at	Funeral Dire	1	e. Street and Number Eastern Bl . Marital Status	Vd. 12. Was Decedent Ever in U.S.	10f. Zip Code	e ?21 of Hispanic Origin? (Spe uban, Mexican, Puerto I		Citizen of What Cou	can Indian,
9003	72 hours after "netural", or Ite	ed by Fur		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 N	No Specify:		Specify: Block	rek
21215-0036	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene, tiem 27 is marked other then "netu other treumetic event, the Medical	Completed by		15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	e completed)	Decedent's Usual Occ Give kind of work doi life. DO NOT use ret	ne during most of working	ng 16b	. Kind of Business/Ir ONS:+VLLC	Fron
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumetic event, the M	To Be	17	Father's Name (First, Middle, Last) OOO YOW ant's Name/Relationship (Ty	rant 19h	Mailing Address (Stre	18. Mother's Name	Bullar	d	Code
	es 1 and of Health fitem 27 r other tr		20	Kose Clark a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ B	20b. Place of I	Black Disposition (Name of crematory or other p	Foote Ct	Beltsu	Location - City or To	20705
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr		2	4 Donation 5 Other (Specify)	Chelfe	Ph Hills 22 Name and Ade	Ol-O	4-2010 PI	hiladelphi . Iox 354	g, PA
	Physician /Medical		In di	3a. Part 1. Enter the disease, or comprishock, or heart failure. List only or mediate Cause (Final sease or condition	cations that caused the death. Do not not cause on each line.	ot enter the mode of d	tying, such as cardiac of	r respiratory arrest,	ungton,	Approximate Interval Between Onset and Death
8760,	be executed existence in the control of the control	ical Examiner	Se if ca	equentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or Injury at initiated events sulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of):				
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ords, P	iw requires that the second se	eted by Pl	Pa	t II. Other significant conditions con Mulh- wifan	tributing to death but not resulting in t	he underlying cause of	given in Part I.	23e. Did tobacc	o use contribute to the	
Division of Vital Records,	The la ate has page 2	e Comple	25	Was case referred to medical	soder.	D W.		24a. Was an autopsy performed 1 Yes 2	prior to co death?	psy findings available mpletion of cause of 2 No
f Vii	Physicien: this certific ral director,	To Be	23	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA	26. Place of Death Other: 4 Nursing Hom	(Check only one) se 5 Residence	6 ☐Other (Specif	iy)
ision o	To the Hospitel or Attending Phwithin 24 hours after death To the Funerel Director: After th completely filled in by the funeral	Certification;	27	Manne of Death Natural 5 Pending Accident investigation Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Tim	ury W M 1[ury at 21 lork? □ Yes 2 □ No	8d. Describe how in	jury occurred	
Div	itel or A	Certif		4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	131 31		8f. Location (Street City or Town, Sta	ite)	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29	a. Certifier (Check only one) A Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, one: On the basis of examination and/ and manner stated.	death occurred at the or investigation, in my	time, date and place, are opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as s nd place, and due to	tated. o the cause(s)
	Tot withi Tot com	M		b. Signature and title of certifier	Ο.	D-	nse number 38754	12	Date signed (Month,	2009.
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	Sta Registr		31.	JAN 0 4	32. Registrar's Signature	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Yrince Georges Hospital 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 102 M 2□ F Months Days Hours Min intant Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Hyattsville Prince Georges 1 PYes 2 □ No Director 10g. Citizen of What Country? Virginia Avenue 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None - Infant NONE - Unfait NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marvel Sharon veruse. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 Virginia AVE #202 Hyattsville, MD 20785 Shavon Denuse Gore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/09 4 □ Donation 5 BOther (Specify) HOSP. Disposi Prince Georges Hosp 22. Name and Address of Facility Prince 666 1965 3001 Hospital 1 21. Signature of Funeral Service Licensee HOSP center 20785 Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Extreme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check onl one) examiner? Other: 1 Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Cheverly MD Hospital

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Albert Hishmeh Jr. Day Month Year 1:25 AM Medical 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Salisbury Wicomico If Under 1 Year If Under 24 Hrs **Funeral** Social Security Number 215-26-5096 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 08/30/1919 Director 90 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 1016 Camden Ave. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Completed by Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: rres, Give Army Year or Dates Army 3 X Widowed 4 Divorced Specify. white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator clothing store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Paul Albert Hishmeh Sr. Edna Cantwell 19a. Informant's Name/Relationship (Type, Print)
Paula H. Hudson/daughter 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 W. College Ave., Salisbury, MD 21801 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 1/4/10 4 Donation 5 Other (Specify) Salisbury, MD Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association Compra 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTIUR PULMONAM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NRUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 🗖 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 21 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SKIBURY

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2100 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit Division of Vital Records, P.O. Box 68760

4

7+18h

State

Medical

27. Manner of Death

Natural

Accident

29b. Signature and title of certifier

Suicide

4 - Homicide

29a. Certifier

(Check

DHMH 17 Rev 7/2009

5 Pending

Investigation 6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

28b. Time of

BUX 173

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Maryla		artment of H			ene 009	43332
	Physici	an	1. Decedent's Name (First) Middle, La	5()				2. Date of Death Month	Day Year	3. Time of Death
2	/Medio		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Dea	12	20 2009 4c. County of Death	000 M
	Lamin	ici	Anchorage Nursi	·	Ctr	Salisb			Wicomic	0
	Funeral Director		5. Social Security Number 6. S		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9 Birthr	place (State or Foreign
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	Many Many	tor	MD Somers	set Pr	incess	Anne				1 Yes 2 No
	or 28	Director	10e. Street and Number		1	10f. Zip Code		10	g. Citizen of What Cour	ntry?
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funerai	11. Marital Status 1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐XNo	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
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ř		Com						autopsy performe	d2 death?	mpletion of cause of 2□ No
VII.	cian artifi actor	Be	25. Was case referred to medical examiner?	Hospital:		104		ath Check only one		
Ö	g Phys er this eral di	٩	1 Yes 2 No 27. Manger of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		41 writersing F	lome 5 ☐ Residen 28d. Describe how	ce 6 □Other (Specify	0
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DIVISION	spital or Atten ours after deat serel Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
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•	L.		> whe help				1359		12/2/109	
	00		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type, I	Print)	Cr C4.	icam.		
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-		Y	1 - State Registrar 1. Decedent's Name (First, Middle, L	act)		U	ertificate d	ot Death	2. Date of D	Reg. N	2009	1 2	333
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	/Medic Examin		4a. Facility Name (If not institution, g		110111		4b. City, Tow	n, or Location of De			c. County of Death		<u> </u>
	11 W		McCready Memori	al Hospital	L		Cı	risfield			Somerse	t	
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=	sicial s certii irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatie	ant 2 🗆	EB/Outpa	tient 3 DOA	Other	eath (Check only		a 🗆 0 /0	*)	
5	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Tim		njury at Work?	28d. Describe		6 □Other (Specury occurred	eity)	
5	ath. ath. r: Aft	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigati		y rear)	Inju		Nork? 1 ☐ Yes 2 ☐ No					
2	or Atter de ter de lirecte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho c. (Specify	me, farm,	street, factory, off	ice	28f. Location City or To	(Street a	and Number or Ru te)	ral Route N	umber,
ַב	pital o		29a, Certifier 1 🔀 Certifying	Physician: To the best	of my kno	wladgo d	anth acquired at th	o time data and pla	on and due to the		a) and manage	-4-41	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit	Medical	(Check only 2 Medical Ex	aminer: On the basis o and manner sta	f examina	tion and/o	r investigation, in r	ny opinion, death o	curred at the time	e cause(e, date ai	nd place, and due	to the caus	e(s)
	To th within To th comp	Me	29b. Signature and title of certifier					ense number			ate signed (Month		*
			(Singm)	PRAD R	. 3	ARA	LIMD	0544	22	1	2-28-	- 20	09
			30. Name and address of person wh	o completed cause of d	leath (Item	23a) (Typ	pe, Print)	0544.	1851				
思	Sta	te	31. Date filed (Month, Day, Year) DEC 3 0 2		ar's Signa	ture		~ ×	1001				
	Registr		UEC 3 0 2	009 Registr	U K	9. 14	race						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3&26 Per Phy C899 1/20/2010 JH state of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hippchen James Francis 29, 2009 December a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 4, 1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Days Hours Min. 577-46-5286 Washington, DC Director Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9626 Cottrell Terrace 20903 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 No. 1956-58 þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) filed within al Hygiene. event, the Optician Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental File of Health and Mental Filem 27 is marked o Peter William Hippchen 2 Agnes Camille Sexton traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hippchen/Wife 9626 Cottrell Terrace, Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Gate of Heaven Cemetery 2, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Jan. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physiciani Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of): Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Peripheral Vascular Disease resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Type II Diabetes Mellitus Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No ed by the detached g 🗌 Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ law requires Division of Vital Records, Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s has prior to completion of cause of death? autopsy performed? the Hospital or Attending Physician: The certificate 1 Yes 2 No Yes 2x No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Naturai injury 5 Pending 1 Yes 2 No Accident investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier P 29c. License number 29d. Date signed (Month. Day, Year)

State

10+

D31282

8218 Wisconsin Avenue, Bethesda, MD 20814

Dec. 30, 2009

omi

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

peut

31

Albert K. Lee,
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12/27/2009 SARAH VIOLA HARRIS 0220 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □XF Months Days Hours Min Jamaica Director Yrs 579-70-7185 Usual Residence of Decedent show 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Montgomery Gaitherburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with Funeral 1006 Westside Drive 20878 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Shours by and Montal Hygiene.

7 is marked other than "r within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper 12 Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Harris traumatic Serephina Irons ge 1 and 2 should b nt of Health and Mei :: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oswald McDonald - son 982 West Side Drive, Gaithersburg, MD 20878 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or once. Souls Cemetery 01/05/10 4 Donation 5 Other (Specify) Germantown, MD 21. Signature of Ineral Service 22. Name and Address of Facility Snowden Funeral Home <u> 246 N. Washington St. Rockville, MD 20850</u> 23a. Part 1. Enter the disease, or complications that caused the deth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disgass, s. shock, or heart failure. List o Approximate Interval Between ly one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory failure Medical Due to (or as a consequence of) **Examiner** CHF Sequentially list conditions if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed COPD and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical P.O. Box 68760 attending p IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 XNo Month Pregnant at time of death Day i signed by the aid be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 YUnknown 24a. Was an 24b. Were autopsy findings available has autopsy perform prior to completion of cause of death? Yes 2 X No certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 [XNo ည 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Brian Carpenter, MD

3

who completed cause of death (Item 23a) (Type, Print)

D0064502

9901 Medical Center Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

12/28/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 28. 2009 Helen Smith Harden December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Westminster Carroll Lutheran Village Health Care Carrol] 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Davs Hours 1 □ M 2 € F Months 95 Director 215-10-6573 Sept 26, 1914 Maryland Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination rotat by notified at 1 ☐ Yes 2 ☐ No Director Carroll Westminster Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 828 Holliday Lane 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify. 2 3 SWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Robert Smith, Sr. Augusta Virginia Preister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD 828 Holliday Lane 21157 William R. Harden son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of h Important: If ite any Injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/4/2010 Eldersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Park 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA Signature of Funeral Service Licens 412 Washington Rd. Westminster, MD 21157 23a. Part Cnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIAN I RS CUV Due to (or as a consequence of): resulting in death) nere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Advance that initiated events resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Month Dav Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depen 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

show

s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 Is marked other than "natural", or Iter

Pages '

Saltimore, Maryland 21215-0036

attending physician and for use as the burial-transil been signed by the a has been certificate

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Completed by in by the funeral director, Be after death,

Hospital or Attending Physician: 24 hours a within 2. State Registrar

25. Was case referred to medical examiner? Certification: To 27. Manner of Death filled

Medical

1 Yes 2 No

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

30. Name and address

5 Pending investigation

6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

24a. Was an autopsy

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bast of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29d. Date signed (Month, Day, Year) 29c. License number

(Item 23a) (Type, Print)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day,

Months

10f. Zip Code

1 ☐Yes 2X No

7. Age (In vrs. last birthday.

10c. City, Town or Location

77

Was Decedent Ever in U.S. Armed Forces?

1 Tes 2 No If Yes, Give Year or Dates:

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs

Davs

ANNAPOLIS

Hours

MAYFIELD VILLAGE

44143

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

4c. County of Death

10a. Citizen of What Country?

UNITED STATES

Specify: WHITE

14. Race - American Indian Black, White, etc.

8. Date of Birth (Month, Day, Year)

AUGUST 30, 1932

ANNE ARUNDEL

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐Yes 2 No

OHIO

Physician /Medical Examiner

Funeral

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

CUYAHOGA

1 M 2 X F

5. Social Security Number

287-26-9049 Usual Residence of Decedent

10e. Street and Number

11 Marital Status

673 SOM CENTER ROAD

1 Never Married 2 Married

3 Widowed 4 Divorced

10a. State

OHTO

Director

Funeral

þ

Director with the Maryland r than "natural", or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. and the first and the first and the first and the first and the first and the traumatic event, the Medical Event insury or other traumatic event, the Medical Event insury or other traumatic event, the Medical Event insury or other traumatic event, the Medical Event insury or other traumatic event, the Medical Event insurance in the first insuranc

Baltimore, Maryland 21215-0036

permit. Pages 1
Department of F
Important: If ite
any Injury or ott **Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran attending p signed by the certificate has briector, page 2 s ours after death.

eral Director: After this of filled in by the funeral dire 24 hours a

Division of Vital Records, P.O. Box 68760

Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 FLORIST FLORAL SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALFRED GOETZ 2 LILA WORTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY M. DELEONIBUS/DAUGHTER 735 INTREPID WAY, DAVIDSONVILLE, MARYLAND 21035 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION DECEMBER 29, CENTER 2009 STEVENSVILLE, MARYLAND 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, I REMATION AND FUNERAL CARI ROAD, ANNAPOLIS, MARYLAND HELFENBEIN AND NEWNAM RE. P.A., 814 BESTGATE D 21401 Will Exone M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASEPTIC MENINGITIS 2 WEEKS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2.ENVo 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 31. Date filed (Mon State

Registrar DHMH 17 Rev 1/2001

completely

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43338 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 2009 William V. Hartleb 8:40 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2939 Knoll Circle Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 213-30-8027 0270371933 Country) Director 76 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Ellicott City MD Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 2939 Knoll Circle United States 12. Was Decedent Ever in U.S Armed Forces? 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1953-Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 2 🗌 No 1955 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal any injury or other traumatic event, the Medical Exal any once. 3 - Widowed 4 - Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Regional Sales Manager Industrial Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William F. Hartleb Gladys Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2939 Knoll Circle Ellicott City, MD Kay K. Hartleb - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State New Cathedral Cem. 4 Donation 5 Other (Specify) 01/04/2010 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. / MO1044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) as / Medical Due to (or as a consequence of): Examine totate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the at Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 2 PNo 3 Probably 4 Unknown 1 🗌 Yes Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? certificate 2 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 1 No Other: မြ 4 Nursing Home : After this of funeral dir 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural within 24 hours arter www...

To the Funeral Director: After 5 Pending Accident
Suicide 1 Tes 2 D No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

30. Name and address of pe

31. Date filed (Month

n who completed cause of death (Item 23a) (Type, Print)

Eneur

2010

egistrar's Signature

4/676

ayoi W. Bul

29d. Date signed (Month, Day, Year)

02

01

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Box 68760, P.0. Division of Vital Records, completely filled in by the funeral To the within 2

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier (Check only

29b. Signature and title of certifier

BONNIE FITZEBERG, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7190 CRESTWOOD BLUD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0065201

29d. Date signed (Month, Day, Year) December 29, 2009

FREDERICK MO

			1 - For State Registrar	State of Marylar			of Health and of Death		giene Reg. No.200	9 43340
	Physici	an	1. Decedent's Name (First, Middle, La	st) malling	1	Ilam	Tind	2. Date of De Month		3. Time of Death
0	/Medic / Examir		4a. Facility Name (If not institution giv	e street and number)	TAL	4b. City, Toy	m, or Location of Deat	01	4c. County of I	Death Georges
	Funeral Director		5. Social Security Number 6. S None Usuel Residence of Decedent	ex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 Hrs ays Hours Min	8. Date of Bir (Month, Da	2/Lung	Birthplace (State or Foreign Country)
	death with the Maryland me 23a or 28a-f show finant be notified at	ctor	10a. State 10b. County	Georges 100. Ci	ty, Town or Lo	exict	- Heigh	475		10d. Inside City Limits 1 ☑Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 3735 DOWN	IN DR # 2	101	10f. Zip Co	20147	7	10g. Citizen of Wha	at Country?
036	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Heelth and Mental Hydene. If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner man be notified at	þ	11. Marital Status 1 Dever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify 1 ☐ Yes 2 ☑	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No o Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc.
21215-0036	within 72 ho ene. than "natur the Wedical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-Aor 5+)	(Give	dent's Usual O kind of work d DO NOT use re	one during most of wo	rking	16b. Kind of Busin	Trisfant
Maryland 2	buld be filed wental Hygie arked other attc event, It	To Be Co	17. Father's Name (First, Middle, Last,		and		TINA	MARI	, Maiden Surrame)	S HAMFTON
	1 and 2 sho Heelth and tem 27 le mother traum	-	19a. Informant's Name/Relationship (HAMPTON 20b. 1	Place of Dispo	35 Josition (Name of	reet and Number or Ri	Date	er, City or Town, Sta SELECT 20c. Location - Cit	Theights mo
Baltimore	permit. Pages Depertment of Importent: If It any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 5 States of Funeral Service Lices)	W Hosp. Disposal Pri	nce Ge	Prince 6	Hosp ddress of Facility	30/2009 Dital Cen	Cheverly,	MD everly MD 20785
in the	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deal one cause on each line.	th. Do not en		dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	te be executed ysician and burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Que to (or as a consector) C		rup	me 6	men	Maner	7
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 \(\text{Live birth} \) 2 \(\text{Fetz} \) Feta 4 \(\text{Pregnant at time of c} \) 9 \(\text{Unknown} \)	al death 3[⊒Ectopic pregr ⊒ Other (specif			23d. Date of Month	
	quires that the de n signed by the a uld be detached f	۵	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	inderlying caus	e given in Part I.		3/	ute to the cause of death?
Il Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed							ormed? dea	re autopsy findings available or to completion of cause of th?
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	1.500		Other	ath (Check only	1/2	
on of	ing Phys	ion: To	1 Yes 2 No 27. Mann of Death 1 atural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		4 ☐ Nursing I Injury at Work? 1 ☐ Yes 2 ☐ No		idence 6 Other how injury occurred	
Division of Vital	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 39a Blace of Isituat At h	ome, farm, st				(Street and Number wn, State)	or Rural Route Number,
	Hospitel 24 hours a Funeral I etely filled	Medical C		nyaician. To the best of my kn. niner: On the basis of examina and manner stated.						
\ \ \	To the within To the	Me	29b. Signature and title of certifier	2		29c. Li	cense number	7	29d. Date signed (Month, Day, Year)
7	4,4		30. Name a address of person	completed cause of death (Ite	a) (T e	Print)	hernery.	Min -	175/2	5/01
=	Sta Registr		31. Date filed (Month, Day, Year)	32. Flegistrar's Sign	ature .	barke	revery	1119.02	0/85	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2009 INGOGLIA 10:10 P M MARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 17, Year 922 1 □ M 2 🖫 F Months Hours Min. 218-12-6948 Vicenia Director 87 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Kingsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21087 11803 Gontrum Road 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) switchboard operator communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Francis McSorley Mary Agnes Nelligan 19a. Informant's Name/Relationship (Type, Print) 3b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $307~{ t Wisteria~Court~S~Bel~Air,~MD}~21015$ Charlene Curry/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Funeral Service State Anatomy Board 655 W. Baltimore Street MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate dause (Final Physician/ disease or condition resulting in death) 1 stac Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year ☐ Pregnant☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) JANVACY D3 2299 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DAVID DUNN

31. Date filed (Month, Day, Year)

21014

BEL AIR, MD.

615 W. MACPHAIL ROAD

State of Maryland / Department of Health and Mental Hygiene Shenice Jones 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Chenice Dorcas Jones 0930 hrs December 18, 2009 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Baltimore Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Min. 214-43-2416 Director 15 Oct 26 1994 MD 1 M 2 X F Country) Usual Residence of Decedent 10d. Inside City Limits Ě 10a State 10c. City. Town or Location Catonsville 1 Yes 2 X No MD Baltimore or items 23a or 28a-f show must be notified at once. hours after death with the Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country 5905 Charmwood Road 21228 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes Black. Yes 2 X No specify 3 Widowed Divorced If Yes, Give Year Specify "natural". þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natinjury or other transmite event, the Medical Exa Elementary/Secondary (0-12) Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Unknown Cecelia Audrey Jones Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5905 Charmwood Rd., Baltimore, MD 21228 Audrey Jones mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 26 2009 Taylorsville, MD Fairview Cemetery 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road, Winfield, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical X AMENDED #1 as noted, 28b, per ME g899 1/20/10 TT UNPENDED signed by the attending physician 1 be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I è 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✔ Inpatient 2 Other Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28a. Date of Injury O800 hrs unk Certification: Dec 16, 2009 Subject hung self 1 Natural 1 Yes 2 ✓ No Director: d in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be Good Shepherd Center, Halethorpe, MD determined (Specify) Group Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states 29b. Signature and title of cert 29c License number 29d. Date signed (Month, Day, Year) December 22, 2009 O.C.M.E. 20 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 3. Time of Death GRAFTON JOHNSON Physician LVESTER 1542 2009 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Pear) | 1940 | May 1 1940 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Maryland 1 TM 2 DF 69 Director 217-38-3408 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sh Examiner must be notified Yes 2 □ No Director Marylan¢ Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 1103 Smithville St. Unit T 10 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item M Elementary/Secondary (0-12) College (1-4or 5+) Recreation & Parks 12th <u>Maintenance</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Johnson ဥ Grafton Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2839 Piscataway Run Dr. Odenton, Md. <u> Vanessa Ballard (Daughter)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place Asburybroadneck Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/09 St. Margarets, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons MOrtuary, West St. Annapolis, Md. Zarry B Assertion 1821 Wm. Rease & Sons Mortua 821 West St. Annapolis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOPULMONARY ARR STT Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine HYPERTENSIVE DISGASE HEART or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an performe 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 7 29d. Date signed (Month, Day, Year) 12 - 22-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BESTGATE ROAD, SUITE 211, ANNAPOLIS 2140.

State Registrar

21215-0036

Baltimore, Maryland

P.O. Box 68760,

of Vital

Division

888

32. Registrar's Signature

ESSANDOH, MO

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 28 **Physician** December Anna Belle Killmon 2009 4:20 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 02/08/1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Hours 217-16-9575 Director 86 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TXYes 2 □ No Director Wicomico Salisbury Maryland 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 803 Springfield Circle 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If Item 27 Is marked other than "natural"; or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cashier grocery store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be E. Marion Outten Georgie I. Mason 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13629 Allen Road, Princess Anne, MD 21853 Preston Killmon Jr/son other t permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place WICOMICO Memorial Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/2/10 Salisbury, MD Park 21. Signature of Funeral Service Licen 22None and Address of Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FILERDSCLEDATI **Physician** /Medical Due to or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Many er of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide 29a, Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and ritle of certifie 29c. License number 29d. Date signed (Month, Dav. Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thimmarayappa 614 Easternshore Dr Salisbury MD 21804 Mahesha M.D. 31. Date filed (Month, Day, 32 Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

			For State	State of	Maryland /		rtment of F			,				1
			Registrar 1. Decedent's Name (First, Midd	le, Last)		001	incate or i	Dealii		2. Date of Dea	Reg. No.2	09	3. Time of	Death 5
	hysici		George Frede		thofer					Month Decemb	Day	2009	5:00	М
	/Medio Examin		4a. Facility Name (If not institution	on, give street and num	ber)		4b. City, Town, or	r Location (of Death		4c. County	of Death	L	
			Holy Cross Ho	spital			Silver	Sprin	ıg		Mo	n tgor	nery	
	ineral rector		5. Social Security Number 577-50-2051	6. Sex 1 □ X M 2 □ F	7. Age (In yrs. last bi	Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Aug. 17	, Year) 1936	Coun	lace (State of try) ningtor	
P	2		Usual Residence of Decedent 10a. State 10b. County		10a City Tay		ofice					4	0d. Inside Cit	u Limito
laryla	sho	'n			10c. City, Tov							'	1 □Yes	,
the M	28a-f	Director	Maryland Mo 10e. Street and Number	ntgomery			ilver Sp	ring			10a. Citizen of	Mhat Coun		
with	3a or						,	_			J	mat ooun	. у.	
leath	items 2:	Funeral	814 Orange D	12. Was Deced	dent Ever in U.S.	13. W	2090 as Decedent of H	ispanic Ori	igin? (Sp	ecify Yes or No-	USA 14. Rad	e - Americ	an Indian,	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tth and Mental Hygiene.	r than "natural", or items 23a or 28a-f show If a Medical Examiner must be notified at	by	1 ☑Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	2 (3 0No	If	Yes, specify Cuba ☐Yes 2 1 No	Specify:	n, Puerto	Rican, etc.)	Blac	ck, White, e v: Whit		
5-0 2 Po	les I	ted	15. Deceder	nt's Education	168	a. Deced	ent's Usual Occup	ation	A of words	. 1	16b. Kind of B	usiness/Inc	lustry	
21. Fe fin 7	lan "r	Completed	Elementary/Secondary (0-12)	est grade completed) College (1-4	4or 5+)	life. D	ind of work done of NOT use retired	turing mos 1)	t of work	ng				
21 ed wi	it, If s			4			Title Ex				Legal			_
(n) =	event,	Be	17. Father's Name (First, Middle,	•						(First, Middle,		ne)		
ryla bluor	narke	은	George L. Kr		40					a Mae W		O	0.11	
Ma d 2 sl th an	7 is r traur		19a. Informant's Name/Relations Charles W. Kr			,	Address (Street Serpent						,	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments	If item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Bemoval from Si	20b. Place o		ition (Name of atory or other place			Date	20c. Location			
timen traen	tant: jury (4 Donation 5 Dother (5	Specify)		01i	vet Ceme	tery	2	n. 2,	Freder	ick,	Maryla	and
Bal permit	any In		21. Signature of Funeral Service	Licensee	1		Name and Addre rancis J O Univer			Funera	1 Home	Inc.	, MD 2	20901
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that can t only one cause on ea	u es the death. Do ch line.								Approximate Interval Betw	veen
	ician		Immediate Cause (Final disease or condition		ation Pne	umon	ia					ļ	Onset and D	eath
	edical miner		resulting in death)	Due to (o	r as a consequence	e of):						-		
LAGI		_	Sequentially list conditions,	D	ratory Fa		e							
P be	nsit	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		ac Arrest	,								
8760, Cate be executed	physician and s the burial-transit	I Examiner	that initiated events resulting in death) Last	V	r as a consequence								<u> </u>	
8760, cate be ex	physic the b	dical		d										
Box 6	attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live bir	ome of pregnancy rth 2 Fetal deatl		Ectopic pregnanc	у				te of delive	•	ear
P.O. I	by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregna 9 □ Unknow	ant at time of death wn	5 🗆	Other (specify)				IVIC	лит	Day	cui
vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certif r death.	en signed	ed by P	Part II. Other significant conditi Coagulopathy	ons contributing to dea	ath but not resulting i	in the und	derlying cause give	en in Part I.			bacco use cont es 2 ☐ No			
Reco	te has be age 2 sho	Completed by					· · · · · · · · · · · · · · · · · · ·			24a. Was a autop perfor	med?	death?	osy findings a	vailable use of
ital	rtifica tor, p	Be C	25. Was case referred to medica	1				26. Place	of Death	1 ☐ Yes n (Check only or		1 □Yes	2 LI No	
f V	direc		examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 € In	patient 2 ER/O	utpatient	3 □ DOA Othe			me 5 Resid		er (Specify	·)	
On O ding Pt	After the funeral	tion:	27. Manner of Death 1 ★ Natural 5 Pendir 2 Accident investi		Injury 28b. , Day, Year)	Time of Injury	28c. Injury Work			28d. Describe h				
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death.	Io the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	3 Suicide 6 Could 4 Homicide detern	not be	I of Injury - At home, fa g, etc. <i>(Specify)</i>	arm, stree				28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	Route Numb	per,
Div	e Funera	Medical (29a. Certifier 1 ☐ Certifyii (Check only one) 2 ☐ Medical	ng Physician: To the base Examiner: On the base and manner	sis of examination a	ge, death ind/or inv	occurred at the tir estigation, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the dred at the time, of	cause(s) and m date and place,	anner as si and due to	ated. the cause(s)	
To th	comp	Me	29b. Signature and title of certifie	er (29c. Licenso			2	29d. Date signe	d (Month, I	Day, Year)	
0	P		Nesh	Sath				D6815	0		Decembe	r 28,	2009	
	`		30. Name and address of person Nejib Siraj,		of death (Item 23a) Forest G			lver	Spri	ng.MD 2	0910			
	Sta Registra		31. Date filed (Month, Day, Year)	32 Bo	gistrar's Signature		_		1	3,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24. 11:43pm 2009 Ronald Hoon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Year 1946 1 X M 2 D F Months Days Hours Min July 04 **Director** 63 Korea 214-90-9026 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 🛣 No Maryland Gaithersburg Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 780 Raven Avenue 20877 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Restaurant Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Lee Ki Young Yim Meuna Jae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Julia Garr - Daughter 3239 S. Utah Street, Arlington, Virginia 22206 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State Norbeck Memorial Park 12/29/2009 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acute Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Myocardial Infarction howr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ☐ Pregnant at time of death
☐ Unknown Month Year Day 5 Other (specify) ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 1 Inpatient 2 🛱 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined

Box 68760 P.O. Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director,

State Registrar

Medical

29a. Certifier

(Check

9901 Medical Center Drive, Rockville, Maryland 20850 Angelo Fálcone. M.D.

DEC 31

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

044340

		For State Registrar	State of N	laryland		artment of He rtificate of D			gienez leg. No.	009	43347
		1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea Month	th	Voor	3. Time of Death
Physicia /Medic		Dollie	Joy Leppo)				Decembe	er 24	, 2009	1347 ^M
Examin		4a. Facility Name (If not institution		r)		4b. City, Town, or I	Location of Death	1	4c. Co	unty of Death	
		Carroll Hospi	ital Center			Westmin				Carroll	
Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 🖫 F	ige (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Year)	9. Birthp Cour	place (State or Foreign ntry)
Director		215-32-0238	101012921	76	Yrs.			May 1,	1933	Tenn	essee
and **		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
// Aarylan f show	ō										1 □Yes 2 🙀 No
the N	Director	MD Car 10e. Street and Number	roll		Westmi	nster 10f. Zip Code			10g. Citizer	n of What Cour	ntry?
with sa or	Ö		Pα			2115	7		USA		
ns 2:	Funeral	2808 Birdview 11. Marital Status	12. Was Deceder			Was Decedent of His	spanic Origin? (S	pecify Yes or No-		Race - Americ	can Indian,
ir iter		1 ☐ Never Married 2 ☐ Mar	Armed Forces			If Yes, specify Cubar		o Rican, etc.)		Black, White,	etc.
al", c	b	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 □ Yes 2√⊋ No	Specify:		Sp	ecify: Whi	.te
72 ho	Completed	15. Deceder	nt's Education est grade completed)	- 1		dent's Usual Occupa kind of work done do		kina ı	16b. Kind	of Business/In	dustry
ithin ne.	ğ	Elementary/Secondary (0-12)	College (1-4o	5+)	`life.	DO NOT use retired)					
ed w lygiel her ti		12			Homen		40 Adathania Nas	(First Middle		wn home	<u>:</u>
be fil tal F ed otl	Be	17. Father's Name (First, Middle,					_	ne (First, Middle,	Maidell Su	mame)	
ould d Mei narke	၉	Thomas G. Fr	•		101. 11.77		Dovie E		- O:t T	Ctata 7	- 0-4-1
and 2 should be filed within 72 hours after death with the Marylanc eath and Mental Hyglene. n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Evanither must be neithed at		19a. Informant's Name/Relations	,			ng Address (Street a					
s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanther must be netitied at		James Leppo 20a. Method of Disposition	son	20h P		Sykesvill psition (Name of	е ка.	Westmins		tion - City or To	.157 own. State
Pages 1 nent of H int: If iter iry or oth		1 Surial 2 Cremation		e Ce	emetery, cier	matory or other place	معصما			-	
it. Partani		4 ☐ Donation 5 ☐ Other (S		Dee		Cemetery	, ,	-			Maryland
permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once.		Splenk K	18 T		4	12 Washin	aton Rd.	ts Fune: . Westmir	ral Ho nster,	ome & C , MD 2	hapel, PA 21157
		23a. Part LEnter the disease, of shock, or heart failure. List	r complications that caus	ed the death							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ASC	VN							Onset and Death YEar 7
/Medical		resulting in death)	Due to (or a	is a consequ	ence of):						
Examiner	L	Sequentially list conditions.	b								
pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequ	ence of):						
ecut and -tran	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	C. Due to (or s	is a consequ	ience of/:						
cate be executed physician and the burial-transit	ᇤ		200 10 (0)		.5.100 5.7.						
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eath certifi attending for use as	N N	IF FEMALE:	23c. If yes, outcom						230	d. Date of deliv	rerv
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w requires that the d been signed by the should be detached	nysi	9 Unknown	9 🗆 Unknowr	1							
s that ned t	by PI	Part II. Other significant conditi	ons contributing to death	but not resu	lting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use	contribute to t	the cause of death?
quire an sig uld b	g pe							1 🗆 Y	'es 2□!	No 3□ Prol	bably 4 Unknown
s bee	Completed							24a. Was			opsy findings available
The lay	E							autop perfor		death?	ompletion of cause of 2 No
sician: The certificate rector, pag	a)	25. Was case referred to medica	1				26. Place of Dea	ath (Check only o		1 🗆 163	20110
Physician: this certifica al director, p	0 0	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2 🗹	ER/Outpatier	nt 3 DOA Othe	r: 4 Nursing F	lome 5 ☐ Resid	lence 6	☐Other (Speci	fy)
ding Ph J. After th funeral	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Ir (Month, I	njury Day, Year)	28b. Time o Injury	f 28c. Injury Work	at ?	28d. Describe h	ow injury o	ccurred	
endin sath. or: A he fu	atic	2 Accident investi	gation				res 2□No				
r Att	۱Ĕ	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 288. Place of I	njury - At ho etc. <i>(Specif</i>)		reet, factory, office		28f. Location (5 City or Tox		Number or Run	al Route Number,
urs al urs al ural D	ပိ										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		ng Physician: To the bearing Examiner: On the basis and manner	of examina							
To th withir To th comp	Me	29b. Signature and title of certifie	er\ ^			29c. License	number		29d. Date s	signed (Month,	Day, Year)
4		► H' + L'	Here In	2		0005	1924	1	1010.	Moer	17,2009
1 DE		30. Name and address of person	who completed cause o	death (Item	23a) (Type,	Print)	4				100 0 7 110
10		Herbert ?. He		×-M()	297	13 Man	Meste	in Kel II	Nanc	leste	4 MIJX116
Sta		31. Date filed (Month, Day, Year)		strar's Signat	ture	6.41					
Registr	ar	DEC 3	0 2009 Den	wa	p. 4	ack					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			State of Mar	yland / De	partment of Health	and Mental Hy	giene 0 0	9 43348
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)	ا ک	4b. City, Town, or Location		4c. County of D	
			Carroll Hospital C	enter		oster	Carr	011
	Funeral		W20	(In yrs. last birthda Yrs	Months Days Hours	or 24 Hrs. 8. Date of Bir (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent			0111	0123	Iowa
	nyland how		10a. State 10b. County 1	10c. City, Town or	r Location			10d. Inside City Limits
	Ba-1 e	Director	Maryland Baltimore	Cato	nsville			1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	t Country?
	eath is 23	Funeral	529 Westside Blvd. 11. Marital Status 12. Was Decedent Ev	ver in U.S. 1	21228 3. Was Decedent of Hispanic C	origin? (Specify Yes or No	USA 14. Race · /	American Indian,
(O	ifter d ir Itan	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 25€No		If Yes, specify Cuban, Mexico	an, Puerto Rican, etc.)	Black, V	Vhite, etc.
93	hours after death with the Maryland turel', or Itams 23a or 28a-f ehow al Examinet must be notified at	d by	If Yes, Give Year or Dates:		1 ☐ Yes \$ ∰No Specif	y :	Specify:	White
21215-0036	72	Completed	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occupation ive kind of work done during mo e. DO NOT use retired)	ost of working	16b. Kind of Busin	ess/Industry
12	within iene.	Jmp	Elementary/Secondary (0-12) College (1-4or 5+))	omemaker		OT-70	home
	e filed within Hygiene. othar than ant, the M	0	17. Father's Name (First, Middle, Last)	n n		her's Name (First, Middle		Totle
ıları	uld be Aental Irkad o	To B	William H. Beacom		El	len Brislan	e	
Maryland	2 should be and Mental Is markad of aumatic even	Ì	19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Num.		er, City or Town, Sta	te, Zip Code)
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Baltimore,	Pages nent of H int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	cemetery, c	crematory or other place)			
ij	그 든 뿐 등		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sept a Licens e	Carvary	Cemetery 22. Name and Address of Fac	12/30/2009		
Ba	Depared Impo		* J. of town		412 Washington			21157
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nonia				Onset and Death
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Вох	death certifi e attending id for use as	cian	in the past 12 months?	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of Month	Day Year
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s, P	The law requires that the tee bas been signed by the base should be detached.	by P	Part II. Other significant conditions contributing to death but		1 1	t I. 23e. Did t	obacco use contribu	te to the cause of death?
brd	v require been si should b	ted	Irchemic Colitis, Atria	1 Abril	lation	1 🗆	Yes 2□No 3□	Probably 4 Unknown
ec	a law r has be	Completed	lanky pop. tv. tarism			24a. Was	psy prior	e autopsy findings available to completion of cause of
Vital Records,						1 ☐ Yes	ormed? deat 22 No 1	
	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No Hospital: 1 ★ Inpatient	2 ☐ ER/Outpar	Other	ce of Death (Check only		0
of	ding Phys h. After this funeral dir	n: To	27. Manner of Death 28a. Date of Injury	28b. Time	e of 28c. Injury at	Nursing Home 5 Aesi 28d. Describe	how injury occurred	эрөспу) ————————————————————————————————————
ion	ath. rr: Afte	atlo	1 Natural 5 □ Pending (Month, Day) 2 □ Accident investigation	Year) Injur	ry Work? M 1 ☐ Yes 2 [□No		
Division	r Atta	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, (Specify)	street, factory, office	28f. Location (City or To		r Rural Route Number,
Ω	pital o		(T. 0. 1/1)					
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medicel Examiner: On the basis of earth one) and manner state	xamination and/or	eath occurred at the time, date a r investigation, in my opinion, de	and place, and due to the eath occurred at the time,	date and place, and	r as stated. due to the cause(s)
	To thi within To thi compl	Me	29b. Signature and title of certifier		29c. License number	г	29d. Date signed (M	Ionth, Day, Year)
	WJL		Balch mano &	20	#53939	7	12/21/2	2009
	20		30. Name and address of person who completed cause of dea	th (Item 23a) (Tyr	pe, Print)	o Charles	oh. I	A.m. 0 41 - C 4
	Sta	to	Babak Imano el, Do 3218 (31. Date filed (Month, Day, Year) DEC 28 2009 January	s Signature	Trights Me	ed Ciry wi	COUNTY OF	MD 21157
:-	Registr		DEC 2 8 2000	A	backer			
DU	MH 17 Pay 1/0/	201	TEG OU COUST NAMED	- 10.	7			

		-	For State of M State Registrar		artment of Health an rtificate of Death		ene _{g. No} 2009	43349
	Dharisis	. ,	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physicia Medic	al :	James Joseph Lombardo		T	Dec.	22, 2009	7:30 A M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Donton	eath	4c. County of Death	
	Funeral		8660 Mitchell Road 5. Social Security Number 6. Sex	ge (In yrs. last birthday)	If Under 1 Year If Under 24 I	Irs. 8. Date of Birth lin. (Month, Day, Y	9. Birt	hplace (State or Foreign
	Director		093-24-0211 1XM2□F	79 Yrs.	World S Days Hours	Aug. 01,	1930 Mic	chigan
	and show	٥	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	Maryls 28a-f otifiec	irect	MD Caroline	Denton				1 ☐ Yes 2 💢 No
	th the 3a or the n	Funeral Director	10e. Street and Number 8660 Mitchell Road		10f. Zip Code 21629	10	g. Citizen of What Co USA	untry?
	ath wi	nue	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Amer	rican Indian.
920	s after de al", or it. Examine	by	Armed Forces?	No Korean	If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 🏹 No Specify:		Black, White	
21215-0036	2 hour "natur	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during most of	working 1	6b. Kind of Business	Industry
12	ithin 7, ene. • than the Me	Com	Elementary/Seconday (0-12) College (1-4 or	5+)	no NOT use retired)		Governme	ent
م 2	iled w Il Hygi other vent, t	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Ma		
ylar	ld be l Menta arked atic e	잍	Carmelo Lombardo		Hele	n Garvey		
, Maryland	id 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Kevin Lombardo / Son	19b. Maili 100	ing Address (Street and Number or 1 Covington Stre	Rural Route Number, C et Baltimo:	ity or Town, State, Zir re, MD 212	3.30°
Baltimore,	permit. Page 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Ⅸ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cre MD Vetera	osition (Name of matory or other place) ans Cemetery		Oc. Location - City or Crownsville	
Balt	permit. Depart Import any inji	() ()	21. Signature of Funeral Service Licensee	B 49	arrandod & sons, 95 Gov. Ritchie	P.A. Sever Hwy, Sever	na Park Fu na Park, M	neral Home ID 21146
	Trysician	0 0	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final	ed the death. Do not ent	ter the mode of dying, such as card	fiac or respiratory arrest		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as	a consequence of):	WE REALT	Dariare		years
· Carrie		-e	Securitally list conditions b. Due to for so	ch Jem c	Cardio mys	pathy		year
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Cerra a	ary artery	disea.	se.	UPACE
	execu an and rial-tra	Ex	that initiated events resulting in death) Last C. Due to (or as	a consequence of):				2
09	ate be hysicia the bu	edical	d					
687	ertifica Iding p	/Me	IF FEMALE: 23c. If yes, outcome				23d. Date of del	liven
Division of Vital Records, P.O. Box 68760	ne death o the atter ched for u	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
s, P.0	ires that the signed by deta	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.		acco use contribute to	the cause of death?
ord	w requ s been s shoul	Completed	-			24a. Was an		topsy findings available completion of cause of
Rec	The lar ate ha page 2	Som				— autopsy perform	ed? death?	s 2 No
tal	ician: sertific ector,	Be	25. Was case referred to medical examiner?		26. Place of Death (0	Check only one)		
Ž	Physic r this caral dir	6: 10	27. Manner of Death 28a. Date of inji	tient 2 ER/Outpatie ury 28b. Time o	of 28c. Injury at	g Home 5 Residen 28d. Describe how		ify)
ouo	ath. r: Afte	icat	1 → Natural 5 ☐ Pending (Month, De 2 ☐ Accident ☐ Investigation	ay, Year) injury	work? M 1 ☐ Yes 2 ☐ No			
Jivisi	al or Atte s after de I Directo d in by th	Certificate:		jury - At home, farm, str tc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Check only one) Certifying Nurse Practioner: To the	examination and/or inves	stigation, in my opinion, death occur	red at the time, date and	place, and due to the	cause(s) and manner stated.
	To the virthing of the complete of the complet		29b. Signature and title of certifier	MN	29c. License number	29	d. Date signed (Month	
1	HIDT		30. Name and address of person who completed cause of Wafik Zaki, MD 920 Market	death (Item 23a) (Type, I	Print)	- 1	- 1	
	Star Registra			rar's Signature	barks			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Beatrice G. Langley 1:15 A M Dec 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Crownsville Fairfield Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, 1 □ M 2 🎖 Months Hours 001-12-2740 87 Director New Hampshire Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland rment of Health and Mental Hyglene. Hart; If flew 22, is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 1184 Bayview Vista 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 White If Yes, Give 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Pediatric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Wilfred L. Gillespie Ruth Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1184 Bayview Vista Annapolis, MD 21409 Jeanne M. Mullen / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial 23, Dec. Glen Burnie, MD 2009 Park 21. Signature of Funeral Service Licens 22. Name and Address of Eacility Barranco & Sons, 495 Gov. Ritchie Severna Park Funeral H Severna Park, MD 21146 P.A. Home Ħwy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final END S Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list oundflura Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death ☐ Pregnam
☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has I performed Yes 2 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? မ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pendina 2 1 No Accident Investigation 124 hours after deat e Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29c. License numbe

State Registrar 31. Date filed (Month, Day, Year)

DEC 28

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1238 Mount Pleasant Drive Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **2** M 2 □ F Min Months Days Hours (Month, Day,) uq. 29 South Carolina 76 248-44-8582 **Director** Aug. 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1238 Mount Pleasant Drive 21409 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1956 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Christopher Locklair, Sr. Ione Gladys Nix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1238 Mount Pleasant Drive Annapolis, MD 21409 Frances Lucille Locklair/ Wife permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 29 1 Burial 2 Cremation 3 Removal from State MD Veterans Cemetery Crownsville, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barrandor Sons, P.A. 495 Gov. Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause Elter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No cate has been signed by the it page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Junknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate ! Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Pranticiper To the best of my investigation, but on the cause (s) and manner as a stated. (Check To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Radistrar's Signature

31. Date filed (Month, Day, Year)

DEC 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stanley Lebar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 132-16-5656 84 Days Hours July 29 **,** 1925 Director ∀ĭrginia Usual Residence of Decedent or 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits by Funeral Director Anne Arundel Severna Park 1 Tes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? USA 10f. Zip Code 407 Severnside Drive 21146 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No 1943 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Yes. Give 1946 Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Westinghouse 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jacob Lebar Gertrude Levenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Severnside Severna Park, MD 21146 Elaine Lebar / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Dec. 30, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify)

21. Sign Ture of Uneral Service Licensee 2009 garranco & Sons, P.A. 495 Gov. Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ OCAV disease or condition d hr. Medical resulting in death) Due to (or s a consequence of) **Examiner** Sequentially list conditions, it and a sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 9 Unknown detached q 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Completed 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has Hospital or Attending Physician; The 124 hours after death.
 Funeral Director: After this certificate I performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 Other: ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of mytha (Check within 2 To the 1 only one 29b. Signat title of certif 29d. Date signed (Month, Dal, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. D. Goldstein, M.D. 116 D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43353 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Deanna Lynn Lofton Dec ว์ดีก9 12:54 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 8. Date of Birth (Month, Day,) June 3, 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 X F Kansas City, MO 579-56-3276 1943 Director 66 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's 1 Yes 2X No Beltsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11218 Cherry Hill Rd, #102 20781 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager 12 Residential Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ralph J. Lofton Jane R. Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Lofton - Son 928 Paulsboro Dr., Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Metopolitan Crematory 12/31/09 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Ragens 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition conditions) Approximate Interval Betwee Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant
9 Unknown Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 2 🗆 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 oo oo 26. Place of Death (Check only one) 2 No Hospital Other: Certificate: To 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De Date of injury 28b. Time of 28c. Injury at work? 1 Alatural (Month, Day, Year) 5 Pending injury 1 Tes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title mpleted cause of death (Item 23a) (Type Print) 217. LATIGO. MD. 207 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Item 24a per verb., 8899,01/19/2010dhb State of Maryland / Department of Health and Mental Hygiene Amend Item 21 per fh, 8899,01/15/10dhb Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Charles Edward Massey 31, 2009 23:54p December /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 07/31/1939 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X**M 2□ F 578-48-2440 70 Director Washington DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shover the Wedical Evaminer must be notified at D.C. Washington 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1108 Varney Street, S.E. 20032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2**X** No **Black** If Yes, Give Year or Dates: 2 Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) יייי wental Hygiene. אס אייי אפון דיייי אפון 127 is marked other than "ר r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Laborer D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Massey Melinda Edmonds မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Jacqueline M. Massey - Wife 1108 Varney Street, S.E.; Washington, D.C. 20032 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glenwood Cemetery 01/08/2010 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services Glenda M. Freeman per DVR 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed signed by the attending physician and is detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been si should I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 autopsy performe this certificate neum spital or Attending Physician: The hours after death. Inneral Director: After this certificate y filled in by the funeral director, pa 1 ☐ Yes 2 X No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

within 24 hours a Hospital

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

1-12-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 104; Dreenhelt, MD HANOVER 7500 ParkWAY 32. Registrar's

29c. License number

29d. Date signed (Month, Day, Year)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u> 20</u>0°9 necember James Robert Mack, Sr. 9:36 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince George's Doctor's Community Hospital Lanham 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Sex 1XXM2□ Months Days Hours Min. Director 214-42-6343 64 Washington, D.C. Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Prince George's Bowie 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 23a or 10f. Zip Code Funeral 20720 7110 Highbridge Road or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 NoUSAF
If Yes, Give Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2XX No Specify: "natural", Specify 3 Divorced Completed 62-1966 Year or Dates. 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Giant Food, Inc. Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gladys Elva Tydings Lawrence Bernard Mack, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7110 Highbridge Road, Bowie, Maryland 20720 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Barbara J. Mack - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 12/30/2009 Brentwood, Maryland emetery . Signature of Juneral Service Lice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Massiv Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury and the burial-tras that initiated events resulting in death) Last Due to (or as a consequence of): ت سرمان عند من المتعافرة Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 3 1 🗌 Yes 2 🗌 No Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) examiner? Other: 1 Yes Certificate: To 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 124 hours after death e Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year)

3

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

J64268

December 26 2009

MD, 20706

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of I	Health ar Death	nd Me		giene A	2009	43356
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
_	ysicia Vledic		Anthony Hector M	imiaga					Month Decembe	er 29	, 2ď%	8:13 am
	vieuic camin		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, o	or Location of I				County of Dea	
			Holy Cross Hospita	1		Silver S	Spring			71	Montg	
Fur	neral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year			3. Date of Birt	h	9. Bir	thplace (State or Foreign
	ctor		229-06-0533 ^{1 🔀}	M 2 □ F 51	Yrs.	Months Days	Hours	Min.	VOV. Ta	1, Year) 19	58 ^{Co}	Spain
	46		Usual Residence of Decedent									
/lanc f shc	ed at	ģ	10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
Mar 28a-	otifie	irec	Virginia -		Alexan	dria						Yes 2 No
h the	pe u	무	10e. Street and Number			10f. Zip Code					en of What Co	ountry?
h wit	nust	Funeral Director	5500 Holmes Run P	arkway, #813			304				USA	
deat	ner	교		Was Decedent Ever in L Armed Forces?	l.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin an, Mexican, F	n? (Specif	fy Yes or No- can, etc.)	14	4. Race - Ame Black, Whit	
36 after [". or	cami	2	1 Never Married 2 X Married	1 ☐ Yes 2 ☒ No If Yes, Give		Yes 2 No				9		hite
Surs Surs	alE	Completed	3 Widowed 4 Divorced	Year or Dates.							, , , , , , , , , , , , , , , , , , ,	
15 րշ հւ	ledic	힐	15. Decedent's Educ (Specify only highest grade		(Give i	lent's Usual Occup kind of work done	during most of	f working		16b. Kind	d of Business	Industry
the state of the s	he N	등	Elementary/Seconday (0-12)	College (1-4 or 5+)		O <i>NOT u</i> se retired) lectric a:		2002		Co	mmerci	2]
C Street	ent, t	യ	17. Father's Name (First, Middle, Last)	2	15.	rectitca.			First, Middle,			.aı
an be fil ental ked	C ev	2	Hector Mimiaga						Bremon	Warden oc	marrej	
ould Me	mati		19a. Informant's Name/Relationship (Type,	Print)	10h Mailie	a Address (Ctreat				City or To	ours Ctato 7	in Cardal
2 sh 2 sh 17 ar 17 is	tran	1	Diane Mimiaga/Wif		5500 I	ng Address (Street Holmes Ru	ın Park	kway,	Alexa	andri	\mathbf{a} , $\mathbf{V}\mathbf{A}$	22304
altimore, Maryland 21215-0036 mit. Page 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural", o	ther		20a. Method of Disposition	20b.		sition (Name of	- 1	Dat			ation - City or	
nol age 1 ant of the Hij	ě		1 🕟 Burial 2 □ Cremation 3 □ Re	moval from State Ga	cemetery cren	natory or other place Heaven Co	emet e ry		ec. 31 2009	,	•	· i
Itin lit. Pe artme ortan	njun		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee									ring, Maryland
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 28a or 28a-f show	any		21. Signature of Fulleral Service Licensee	hours	F. 5	rancis ^{Addre} 00 Unive	rsity F	ins F	uneral	L Hom	e Inc.	ng, MD 20901
		\dashv	23a. Part 1. Enter the disease, or complication	ations that caused the dea								Approximate
			shock, or heart failure. List only one of Immediate Cause (Final		in. Do not citte	in the mode of dyn	19, 00011 00 001	ardido or re	copilatory an	000,		Interval Between Onset and Death
Physic Med			disease or condition resulting in death)	Intracrania		đ						
Exam				Due to (or as a consec	100.5							
		<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Thrombocyto Due to (or as a consec								
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kecul	al-trai	ا <u>چ</u>	that initiated events c. resulting in death) Last	Advanced Le								
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760 cate b physi	s the	ed:	a.									
68 Sertific	Ise a	ا §	IF FEMALE: 23b. Was decedent pregnant	. If <u>ye</u> s, outcome of <u>pr</u> egr						22	3d. Date of de	divery
Box death o	for	cia	in the past 12 months?	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnant Other (specify)	СУ			-	Month Month	Day Year
. e +	ched	Physician/Me	g Unknown	9 Unknown		., ,, ,, =						
P.O that th	deta	<u>~</u>	Part II. Other significant conditions contr	ibuting to death but not re	sulting in the u	nderlying cause gi	ven in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
S, lires	ld be	g p	Respiratory Failur	e					1 🗆 \	∕es 2 □	No 3 □ F	robably 4 KM nknown
ord requ	shou	e e							24a. Was a	ın T	24b. Were au	topsy findings available
Records, The law requires	2	Completed							autop	sy	prior to death?	completion of cause of
i: The	r, pa		25. Was case referred to medical						perfor 1 Tes	2 📑 No	1 🗌 Yes	s 2 No
ita sicia certi	rectc	m̃	examiner?	spital: 💥	7		lace of Death (
Phy rthis	ral d	유	27. Manner of Death	28a. Date of injury	28b. Time of	t 3 □ DOA 28c. Injur			e 5 ∐ Resid d. Describe ho		Other (Spec	cify)
n Ging	fune	l ät	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work	(? Yes 2 □ No		a. Describe in	ow injury c	ccarred	
SIO Atten	y the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre		100 2 2 110	_	f Location (S	treet and I	Vumber or Bu	ral Route Number,
DIVISION Of VITAL tal or Attending Physician: s after death. al Director: After this certifi	i d		4 ☐ Homicide determined	building, etc. (Special	(y)	, ,,			City or Town		varrio or or ria	, an industry tarribon,
Jro the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate it	₫	ca		an: To the best of my know								
ie Ho 1241 e Fui	oletec	Medical	(Check 2 Medical Examiner		on and/or invest	igation, in my opinio	on, death occur	irred at the	e time, date ar	nd place, a	nd due to the	cause(s) and manner stated.
o th	com	— r	29b. Signature and title of certifier		<u> </u>	29c. License					signed (Monti	
V			Drille .		M.D.	, D6	4100			Dece	mber 2	9, 2009
		-	30. Name and address of person who com	pleted cause of death (Itel		rint)						
			Smitha Bhikkaji,			len Road,	, Silve	er Sp	oring,	MD 2	0910	
اسلاة	State	e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	Acres a management							
Reg	gistra	r	DEC 3 1 2009	Deneral B.	Jane	Carlot I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3134AM Barbara Jean Moore Medical 4a Facility Name (if not institution, give street and number Examiner 4c. County of Death bur COMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2🛣 F Months Days Min Director 213-42-2234 65 Usual Residence of Decedent oortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD Wicomico Parsonsburg 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 6682 Forest Grove Road U.S.A. 21849 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic areast than the status. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Officer Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Omar L. Higgins <u>Odessa Holloway</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Noore Leroy S. Moore/Husband 6682 Forest Grove Rd, Parsonsburg, MD 21849 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) endship UMC Cem1/2/2010 Wetipquin, MD 2 Signature of Funeral Service Licenses 22. Name, and Address, of Facility 917 W. Isabella St Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MRTASTATIC disease or condition COLOPECTAL Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any modify to in modate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abuses and the strength of the properties and the attending the strength of the Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Yes 25. Was case referred to medical To Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 1 Tyes P1 42 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury Investigation Could not be 1 Yes 2 No Accident Suicide 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 🎢 nd title of certifie D005346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

6 Hunan

AN 1 4 2010

istrar's Signature

			1 - For State of Maryland / Depa Cert	riment of Health and M Fificate of Death		ene g. No. 2009 43358
	Physici	an	1. Decedent's Name (First, Middle, Last) Thomas Musgrove		2. Date of Death Month	Day Voor
N. S. D.	/Medio			4b. City, Town, or Location of Death	Pea	4c. County of Death
and de	<u>.</u>		Washington County Hospital	Hagerstown		Washington
	Funeral Director		5. Social Security Number 214-24-4765 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, June 22	Year) 9. Birthplace (State or Foreign Country) MD
	how how		10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
	he Ma 8a-f s	ecto	MD Washington Little	Orleans		1 □Yes 2 및 No
	3a or 3	Ä	10e. Street and Number Route 1, Box 127	10f. Zip Code 21766	10	g. Citizen of What Country? USA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanifish ment be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Very New 1952 -	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0036	ours aft rall, or Evani	by	3 X Widowed 4 □ Divorced If Tes, Give 1954 10	□Yes 2 ¼ No <i>Specify</i> :		Specify: White
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70,	To t	Σ	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
•	WJL	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	10061117	De	grenler 24, 2009
0	+''		Francisco A Daviel DO	HOSESTON		21740
	Stat Registra	_	31. Date filed (Month, Day, Year) DEC 2 9 2009 Servers A.	3		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Andrew С. December 2009 1:25pm /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner e Sykesviiii 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. June 30, 1924 Transitions Health Care Carroll 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 17 M 2□ F Director 044-18-6709 Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Iteme 23s or 28s-f ehow the Madical Examiner must be notified at 1 Yes 2 No Carroll Sykesville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6611 Marvin Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∭ Yes 2 □ No If Yes, Give Year or Dates: WW I ☐ 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【▼No Specify. þ Specify: White 3 Widowed 4 Divorced and Mental Hygiene. le marked other then "natural", WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Officer Air Force permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth eny jury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pascal Manzo Marietta Pepe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Tasha Manzo (Wife) 6611 Marvin Avenue Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12/29/2009 Sykesville, MD 21. Signature of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, P.A. MOOTEG PU Box 195 Sykesville, MD 21784 Tu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) menoner Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit the Hospital or Attending Physician: The law requires thet the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the ettending physicien page 2 should be detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes : After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No after death | Director: / d in by the fi 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) MJI D0050763 12+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 826 Washington Rd Ste. 120, Westminster, MD Emesto Mendoza, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner

Physician /Medical Examiner

P.O. Box 68760,

Division of Vital Records.

8. Date of Birth (Month, Day, Year)
July 01,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 88 Months Days Hours Min. 248-24-8142 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 133 Wild Oak Road 21146 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 17. Father's Name (First, Middle, Last) Be John Varde Wix ပ 19a. Informant's Name/Relationship (Type. Print) Emma M. Hofford / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Dec. ري 2009 **,** 1 X Burial 2 ☐ Cremation 3 X Removal from State Chester Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) of Faneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregi 3 Ectopic pregnancy in the past 12 mor 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Completed 24a. Was an has 2 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manne Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 21 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ans Hwy Millersville MD 21108

1 - State Registrar 1. Decedent's Name (First, Middle, Last) Alice Azalee Wix McWatters 2009 Dec. 22, P^{M} 6:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Future Care Chesapeake Arnold Anne Arundel 9. Birthplace (State or Foreign South Carolina 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Home 18. Mother's Name (First, Middle, Maiden Surname) Alice Teresa Levister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Wild Oak Road Severna Park, MD 21146 20c. Location - City or Town, State Chester, SC Harrand Ades Solisi, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Desire Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Anne, Nardtck 5:16 19th December 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Battimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months 1 □ M 2 🖼 F Days Wash/DC <u>578-86-5415</u> 8/25/1958 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 🛠 😾 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1834 St. Margarets Rd. 21409 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2√ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baggage Claims 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert J. Hughes Angela M. Sheehan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1834 St. Margarets Rd. Appropriate of Disposition (Name of Date 20c. Location - City or Town, State Joseph Nardick Jr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 12/24/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sowice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nour Interceptal hemorrhage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 🗆 No

'hysician /Medical Examiner

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Examination once.

Baltimore, Maryland 21215-0036

Director

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attending physician and for use as the burial-tran

Records, P.O. Box 68760, Vital oţ Division

95 is Der Mi

the Hospital or Attending hin 24 hours after death, the Funeral Director; After npletely filled in by the

Certification: Medical

State Registrar

5 Pending investigation 2 Accident 3 Suicide 6 ☐ Could not be determined 4 Homicide 29a. Certifier

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

(Check only one)

1 Natural

2 1 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

RES-001

29d. Date signed (Month, Day, Year) Pecember 20th, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheng-fu Lo, M.D. 4940 Eastern Avenue, Battimore, MD 21224

31. Date filed (Month, Day, Year)

DEC 30

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	rtment of F <i>tificate of</i>	Health and <i>Death</i>	l Mental Hy	giene Reg. No.2	11114	43362
	Physici		1. Decedent's Name (First, Middle, Las Walter T. Nolte	t)					2. Date of De Month Dec. 2	eath Day 200	Year	3. Time of Death 1: 24 P M
	/Medic Examir		4a. Facility Name (If not institution, give		cilit	v	4b. City, Town, o			4c. Cc	ounty of Deat	h
	Funeral Director	Г	5. Social Security Number 6. Se		99	-	If Under 1 Year Months Days			rth ay, Year)	9. Birt	hplace (State or Foreign untry) chigan
	aryland show	į	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ith the M	Director	MD Montgome 10e. Street and Number			thesda	10f. Zip Code			10g. Citizer	n of What Co	
0	I within 72 hours after death with the Maryland jeen. r than "natural", or items 23a or 28a-f show the Medical Evandher rust by profflied at	Funeral	5101 Ridgefield R 11. Marital Status 1 Never Married 2 Married	d. Apt. 30 12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Z} \)	ver in U.S.	13. V	Vas Decedent of F Yes, specify Cuba		(Specify Yes or No erto Rican, etc.)		Race - Ame Black, White	rican Indian,
15-0036	72 hours a 'natural'', o dical Evan	eted by	3 XWidowed 4 ☐ Divorced 15. Decedent's Edi (Specify only highest grav	If Yes, Give Year or Dates:		16a. Deced	☐Yes 2 1 No ent's Usual Occup	Specify: pation during most of w	vorking	16b. Kind	of Business/I	Industry
[Z] Z	를 축 분	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5-	+)	_	kind of work done OO NOT use retired TYET		ame (First, Middle	Dept.	of Ju	
ryland	0 = 0 5	To Be	Harry S. Nolte 19a. Informant's Name/Relationship (7	ina Print)	1	405 14-11-	A 111 (Q1	Mary G	race Thr	ush		
e, Mar	1 and 2 sl Health an em 27 is i ther trau		Robert Nolte / So		20h Blo	15 Do	gwood La	ne West	Hartfor	d, CT	06117	
банттог	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic enone.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	1		ional	sition (Name of patory or other place Cremator	y 01/	01/2010	Falls	tion - City or	ch, VA
n D	Dermi Depa Impo any Ir		21. Signature of Funers & ryce ₃ Licen	may		5	130 Wisco	onsin Av	loseph Ga re. NW Wa	shingt		C 20016
4	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Aspirati	ion Pr	neumor		ig, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death Weeks
	Examiner	<u></u>	Sequentially list conditions,	Due to (or as a Dementia	a							Years
В	ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
00/00	ifficate be g physicial as the buri	edical		d								
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 🗖 Fetal d	eath 3	Ectopic pregnanc Other (specify)	у	-81000	23d	d. Date of deli Month	ivery Day Year
ecords, r	quires that en signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulti	ng in the un	derlying cause giv	en in Part I.				the cause of death?
וומו חפככ	an; The law re tificate has be or, page 2 sho	e Completed	25. Was case referred to medical					00 Plane of D	24a. Was auto perfo 1 □ Yes	psy ormed? 2 XNo	prior to d death? 1 ☐ Yes	topsy findings avallable completion of cause of 2 □No
5	Physician r this cerural direct	To Be	examiner?	lospital: 1 ☐ Inpatier 28a. Date of Injur		R/Outpatient		er: 4 🗆 Nursing	Home 5 Resi	dence 6 5	Other (Spec	T 44
NISION NISION	Attending or death. rector: Afte by the fune	Certification:	1 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day, 28e. Place of Inju- building, etc.	(Year)	Injury		Yes 2 □ No	28f. Location (Street and N		ral Route Number,
5	ospital or hours afte uneral Dir ily filled in		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowle	edge, death	occurred at the tir	ne, date and pla	City or To	cause(s) an	nd manner as	stated.
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	ner: On the basis of and manner stat	ted.	and/or inv	29c. Licens		curred at the time,	29d. Date s	igned (Month	
	5		30. Name and address of person who co	empleted cause of de	eath (Item 2	3a) (Type, F	D3945	6		12/31	/2009	
			Lila T. McConnell 31. Date filed (Month, Day, Year)	MD 5530 W	iscons	sin Av	re. #1400	Chevy	Chase, M	D 2081	5	
	Stat Registra		DEC 31 200	9 October	. o oignatur	par	Mad.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joseph Edward Notich December 030, 2009 **Physician** 7:14 P_{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** 88 176-14-6979 Director Aug. 24. 1921 Beaverdale, PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examinat must be notified at MD Carroll Westminster Director 1 ∐Yes 2 TNo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21157 U.S.A. 507 High Acre Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 2 No. 1942 Black, White, etc 1 Notes: 1942 If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Maryland 21215-0036 White 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NASA Elementary/Secondary (0-12) College (1-4or 5+) Computer Operation Specialist permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, II 17_Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Unknown 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Dr., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) 6200 Mark Notich Son Date 4, Baltimore, 20b. Place of Disposition (Name of EVERY CENTER PARTY 2010 Cettysburg, PA 20a. Method of Disposition Jan. 1X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pritts 21. Signature of Funeral Service Funeral Home & Chapel, P.A me 10 21157 412 Washington Rd., Westminster. 23a. Part 1. Ent state disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nevastien disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen (24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 ☐ Yes 2 ☑No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Pour Liveus Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier To the Host within 24 ho To the Fund completely f 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJZ 10. 30. Name and address of person who completes of death (Item 23a) (Type, Print) NA Aberender Box 31. Date filed (Month, Day, Year) State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joan Cecilia O'Toole Physician/ Month Dec. 24 2009 1:00 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Stella Maris Hospice Timonium Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 05, **Funeral** 9. Birthplace (State or Foreign 213-46-3470 1 □ M 2 🕍 F Months Days Hours Min. Maryland Director 1944 Usual Residence of Decedent 28a-f shov 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 XNo ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 121 Roads End Lane 21146 USA Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc Completed by 1 Never Married 2 X Married ☐ Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕅 No Specify: White If Yes, Give 3 Divorced 4 Divorced Specify: Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Albert Vernon Reese Cecilia A. Curley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. O'Toole, Jr. /Husband 121 Roads End Lane Severna Park, MD 21146 DECEMBER 20a, Method of Disposition 20b. Place of Disposition (Name of Dec. 30, 2009 20c. Location - City or Town, State cemetery, crematory or other place)
New Cathedral Cemetery 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signatura Funeral Service Licens Barranco & Stris, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) OVARIAN CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burtal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death Month Day Year 1 ☐ Yes 2 **2** 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2**X** No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760 Fay to ME /ot

		For	State of				K. Ensure A Health and I	•		Legible.	
		1 State Registrar			Cer	tificate of L	Death	1	Reg. No.	2009	43365
Physicia Medi	cal		Roland P		r.			2. Date of D Month DECEMB	Day	Year 1 2009	3. Time of Death
Examir	ner	4a. Facility Name (if not institution, gives SINAL HOSPLT)		BALT	MORE	4b. City, Town, o.	r Location of Death	CITY	4c. 0	County of Death N/R	
Funeral Director		Social Security Number 6.		. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Dec 18		9. Birth	place (State or Foreign ntry) nsylvania
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the Ma or 28 e noti	Ö	Maryland Carrol 10e. Street and Number	<u>. L</u>		West	minster 10f. Zip Code			10g. Citiz	en of What Cou	
n with is 23a nust b	Funeral Director	1303 Arnold Ro	i			2	1157		US	SA	
r item iner n		11. Marital Status	12. Was Decede Armed Force	es?	If		ispanic Origin? (Sp ın, Mexican, Puerto		- 1	4. Race - Ameri Black, White,	
s after ral", o Exam	sq ps	1 ☐ Never Married 2 ☒️Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	2□ № 19 es. 19	1	☐ Yes 2 📉 No	Specify:		S	pecify: Whi	
2 hour "natu edical	plete	15. Decedent's (Specify only highest g	Education		16a. Deced	ent's Usual Occup	ation during most of work	dna	16b. Kin	d of Business Ir	
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illed w Il Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)			<u> </u>	ales	18. Mother's Nam	ne (First, Middle		<u>Estate</u> _{Imame)}	2
Id be I Menta arked atic e	₽	Roland Walter	Pool				Dorot	hy Bell	<u>_</u>		
Shou h and 7 is m traum		19a. Informant's Name/Relationship (and Number or Rur				,
Healt FHealt Item 2		Nancy L. Pool 20a. Method of Disposition	wife	20b. P		Arnold 1	Rd. W∈	estminst Date	T	D 2115 ation - City or T	
Page nent or nent or ant: If in or		1 → Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from Si	late		Mom Car	rdens 12/			•	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer		1EVE	22.	Name and Addres	ss of Facility rit	ts Fune	ral E	Iome & C	hapel, PA
20 E 8 9		July 1-19			41:	2 Washing	rton Rd.	Westmir	ster,		21157
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each	ı line.							Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	a. R INT	as a consequ	ence of: A	HE MORI	RHAGE W	OITH S	UBFA	ALCINE INTICH!	3 days
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rtifical ling ph e as th	/Me	IF FEMALE;	00 - 15								
To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total to the funeral director.	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 🗆 Fetal Int at time of d	Ideath 3 🗌	Ectopic pregnance Other (specify)	у		23	d. Date of deliv	ery Day Year
that the		Part II. Other significant conditions						23e. Did t	obacco use	contribute to t	he cause of death?
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The law re ate has be page 2 sh	Completed by	PAROXYSMAL	ATRIAL	FIBI	RILLA	TION		24a. Was auto perfo 1 Yes			psy findings available mpletion of cause of 2 No
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y Phys er this eral dii	e: 1	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of	3 ☐ DOA Ourie	4 ☐ Nursing Ho	ome 5 Resi			"
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the Hosp hin 24 hou the Funer upleted fil	Medical	only one) 3 L Certifying Nur	niner: On the basis	of examination	and/or investig	gation, in my opinio	n, death occurred a	t the time, date a	and place, a	nd due to the ca	use(s) and manner stated.
2328		29b. Signature and the of certifier					-000		Decem		1,2009
4		30. Name and address of person who AMIT BI-IIS &				int) 2401 W	AL OF	ere Ave BALTI	MOR	ltimore	, MD 21215
Stat Registra		31. Date filed (Month, Day, Year) DEC 2 8	32. Red	strar's Signatu	ire	0.4.1					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29c per DVR G899 1/21/10 dk.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sr. 000 700 M Joseph Rodman Parker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Ragional Medical Center alisbur Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 61 Min. Maryland 218-48-5379 Director Usual Residence of Decedent items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🕱 No Maryland Wicomico Pittsville 10f. Zip Code 21850 10e. Street and Number 10g. Citizen of What Country? 34770 Poplar Neck Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 5 Completed by 1 Never Married 2 Married ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", Specify: white 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) 12College (1-4 or 5+) automotive mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth A. White Rodman J. Parker 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32572 Morris Leonard Rd., Parsonsburg, MD 21849 and is m 19a. Informant's Name/Relationship (Type, Print) Joseph Parker Jr/son item 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery 1/6/10 Pittsville, MD R. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. > not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line INFARCTION Immediate Cause (Final disease or condition BOWEL Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner THEROSCLEROTIC Secuentially list over the on Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🔲 Yes Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signato 29c. License number 29d. Date signed (Month, Day, Year) D34593 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Marylar	Hy Permit. Pages 1 and 2 should b
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Division or Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed
Division or Vita	l or Attending Physician:

			For State Registrar	Sta	ate of I	Marylan	nd / Depa	artment rtificate			and M		giene Reg. No	000	Ω	1.2267
	Physici	an	Decedent's Name (First, Mid-	,,		DAD			0, 5	-		2. Date of De	ath Da	y Yea		3. Time of Death
rigg.	/Medic		4a. Facility Name (If not instituti	ELVA	M .	PAR	VD	4b. City, T	own or l	ocation o		Decembe		8, 200 County of D		10:40 A ^M
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_	Funeral		5. Social Securify Number	6. Sex			last birthday)	If Under 1	Year	If Under 2		8. Date of Bir (Month, Da	th		Birthpla	ace (State or Foreign
	Director	Ì	212-10-4711	1 □ M 2	2 X F	92	Yrs.	Months	Days	Hours	Min.	12/05			Count arv	land
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	anylan show d at	_	10a. State 10b. Count	•		10c. Cit	ty, Town <i>o</i> r Lo	cation isfiel	a						10	d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	death with the Maryland ims 23a or 28a-f show r must be notified at	i	10e. Street and Number					10f. Zip (10g. Ci	tizen of What		ry?
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	rried 1	rmed Force ☐ Yes 2 Yes, Give ear or Date	s? No		f Yes, specif 1 ☐ Yes 2		Mexican Specify:	, Puerto F	cify Yes or No Rican, etc.)	,	Black, W	hite, e	tc.
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yla	Meni arked	2	Elmer A. Matth							Sa	die S	Switze	<u> </u>			
Maryland 21215-0036	l 2 sh h and l Is m raum		19a. Informant's Name/Relation		· .		19b. Mailir	ng Address (Street an	d Numbe	er or Rurai	Route Numb	er, City	or Town, State	e, Zip (Code)
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nor	ages int of it: If its / or o		1 ☑ Burial 2 ☐ Cremation		al from Sta	16	Place of Dispo cemetery, crei							•		
Baltimore,	artme ortani Injury		4 □ Donation 5 □ Other (Sur	nyridge 22	Name and	Address	of Facility	12/30 v	,		isfiel	d, .	MD
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			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complication at only one cau	ns that caus use on each	sed the deat line.	h. Do not ent	er the mode	of dying,	such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	150	401	nic	CA	Rid	w	144	05218	The	3	6	servis
	Examiner		, , , , , , , , , , , , , , , , , , , ,		Due to (or	as a conseq	uence of):				11.54				9	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Dua to (or	ae a euneeq	uenes of):									
	outed id ansit	Examiner	triat initialed events	5 .												
0	ate be executed hysician and the burial-transit	Ex	resulting in death) Last		Due to (or	as a conseq	uence of):									
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d											+	
9 X	centific ding p	/Me	IF FEMALE:	23c If	ves outcor	ne pf pregna	ancy									
Box	uires that the death certific signed by the attending p d be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	11	Live birth	2 ☐ Feta	aldeath 3□	Ectopic pred					T.	23d. Date of Month		y Day Year
0	the c y the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Unknowr											
σ,	s that med b e deta	by P	Part II. Other significant condit	ions contribut	ing to death	but not res	ulting in the u	nderlying cau	ise given	in Part I.		23e. Did t	obacco	use contribute	to the	cause of death?
Records,	w require been signature should b	ed k										1 🗆	Yes 2	Z No 3□	Proba	bly 4 □Unknown
ecc	has be	Completed										24a. Was		24b. Were	autop	sy findings available pletion of cause of
	The ate h	Con											rmed? 2 No	death	?	2 No
Vital	iician; Th certificate ector, pag	Be (25. Was case referred to medic examiner?					-			of Death	(Check only o	one)			
or	Physician: this certific	은	1 Yes 2 No	Hospita	1 🔲 Inpa		ER/Outpatien		1	4 MUI				6 □Other (S	pecify)	1
	ling After fune	ion	27. Manner of Death 1	ng	a. Date of I (Month, i	Day Year)	28b. Time of Injury	M 286	Work?			8d. Describe	how inju	ry occurred		
Division	Attending r death. ector: After	icat	3 Suicide 6 Could		e. Place of	iniury - At ho	ome, farm, str			es 2∐1	-	9f Location /	Stroot as	nd Number or	Ruml	Route Number,
Div	ospital or A hours after uneral Dire ly filled in b	Certification:	4 ☐ Homicide deter	mined 200	building,	etc. (Specif	y)	,				City or To	wn, State	e)	r larar	rioate warmber,
		Medical C	29a. Certifier 1. Certify (Check only one)	ing Physician I Examiner: C	: To the be on the basis	of examina	wledge, death	occurred at vestigation, i	the time	, date an	d place, a th occurre	nd due to the ed at the time,	cause(s	and manner d place, and	as sta	ited. the cause(s)
	To the H within 24 To the F complete	Me	29b. Signature and title of certific			oratou.		29c.	_icense r	number			29d. Da	ate signed (Mo	onth, D	Pay, Year)
			1/1/	727	200	-120			0:	39	816	1	/	2/2	,9	109
			30. Name and address of person	who complet	ed cause o	f death (Item	n 23a) (Type,	Print)	Pa	9	/			2/2	1	1
			21 Data filed (Month Day You	135	20 1	lun	7	01 11.	sel	Mu	ylu	voy	R	Sie	Let	ans
	Sta Registr	te ar	31. Date filed (Month, Day, Year DEC 3	2009	Sz. Fegi	strar's Signa	n 23a) (Type, 2 ature	ake						,-	21	817

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/20/2009 HENRY WELLINGTON PAGE 15:01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 03/27/1934 Director 214-32-8897 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 XNo MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 15005 Darnestown Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 196
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 2 D No 1961-"natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 1963 Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor MD State Highway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked c any injury or other traumatic eve once. ပ Henry R. Page Hanna F. Basil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5610 Buncombe Rd, #705, Shreveport, LA 71129 Wellington D. Page - son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from 4 Donation 5 Other (Specify) 12/28/09 Hill Cemetery Unison, VA Funeral Service Lice Signat 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the dise se, or complications that caused the deat Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Oays shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Septic shock disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner days Bacteremia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Physician: The law requires that the death certificate be executed Cause (Disease or iinjury days Multiple organ failure that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician Physician/Medical Box 68760 as IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy page performed? death? 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2X No 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA P After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/20/09 D0064235

State Registrar Loel Buzy 99
31. Date filed (Month, Day, Year)

9901 Medical Center Drive, Rockville, MD 20850

37. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 21:38 ⁴PM 2009 31 December Lillian B. Pugh 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Hospital of Cecil County E1kton Ceci1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Important: If the 12 is norther traumatic event, Important in the 12 is norther any injury or other traumatic event, Important in the 12 is any injury or other traumatic event, Important in the 12 is a second in the 12 i

Physician

/Medical

Examiner

Funeral Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	OHIOH HO				- 1 "	1	4 1 1	If Under 1 Ye	OF 1 16	Under 24	Hre o	. Date of Bi	urt la		O Dietl	place (State or Foreign
	5. Social Security Nu 240-16-3	964	6. Sex	M 2 ∏ F	7. Age (In yrs			Months Da			Min.	(Month, D	lay, Year		Col	pplace (State or Foreign White Top ginia
	Usual Residence of I	10b. County			10c. C	ity, Town	or Loca	tion								10d. Inside City Limits
ō	Maryland	Ceci	1				cton									1 □Yes 2X No
rect	10e, Street and Num							10f. Zip Cod	de				10g. C	itizen of W	hat Co	untry?
<u> </u>			1	D 1										ited		
era	3042 01d	EIK N			edent Ever in U	J.S.	13. Wa	219 as Decedent res, specify (anic Origin	n? (Speci	fy Yes or N			_	rican Indian,
F	1 Never Marrie	ed 2□ Marr		Armed For 1 ☐ Yes If Yes, Gi	orces?						Puerto Ri	can, etc.)		Black	c, White	e, etc.
þ	3 K Widowed 4	Divorced		If Yes, Gi Year or D	ive^^^ ates:		11	Yes 2	No S	Specify:				Specify:	1	White
leted	(Speci	15. Decedent fy only highes	t's Educa st grade (ation co <i>mpleted)</i>		16a.	Decede (Give ki	nt's Usual Oo nd of work do NOT use re	ccupatio	n ing most o	f working		16b.	Kind of Bus	siness/l	ndustry
Be Completed by Funeral Director	Elementary/Secon	idary (0-12)		College (1-4or 5+)			emaker						Own	Home	е
Be C	17. Father's Name (I	First, Middle,	Last)						18	. Mother's	Name (i	First, Middle	e, <i>Maid</i> e	n Surname	e)	
Lo	John C	hurch								Rł	noda	(Unkr	nown)		
	19a. Informant's Na							Address (St								
	Darrell M		Pug	;h / G				Old El		eck F			_			
	20a. Method of Disp 1 ☑ Burial 2 ☐ 4 ☐ Donation	Cremation		moval from		cemeter	y, crema	tion (Name o Itory or other Metho metery	place)	t Ja	anuar 2010	y 4,			•	Town, State Maryland
	21. Signature of Jur	-			S UI	iui ci		Name and A				ich Fu	·			
1	1///		/				12	7 Sout	h M							aryland2190
	23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List Final	complication only one	cause on e	caused the dea each line. Or as a conse	00	-	the mode of	dying, s	such as ca	ardiac or I	respiratory	arrest,			Approximate Interval Between Onset and Death
er	Sequentially list con	ditions,	b.	Due to	or as conse	uence d	of):									
cal Examir	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c.	Due to	(or as a conse	quence c	of):									
ted by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 2 9 ☐ Unknown	nonths?	23	1 🔲 Live	itcome of pregr birth 2 Fet gnant at time of nown	tal death		Ectopic pregi Other (s <i>pecil</i>						23d, Date Mor		ivery Day Year
d by Ph	Part II. Other signifi	cant condition	ons conti	ributing to d	leath but not re	sulting in	the und	lerlying caus	e given i	in Part I.						the cause of death?
Complete	,										_	24a. Wa aut per 1 🗆 Yes	opsy formed?	p	rior to death?	utopsy findings available completion of cause of 2 \(\square\) No
Be (25. Was case referre	ed to medical	-							6. Place o	of Death (Check only	one)	_		
	1 Yes 2		Ho		Inpatient 2				Other:			e 5□Re				cify)
ation:	27. Manner of Death 1 Natural 2 Accident	ı 5 ∏Pendin investiç		28a. Date (Mor	of Injury oth, Day, Year)		Time of njury		Injury at Work? 1 □ Yes	t s 2⊡No		ld. Describe	e how inj	jury occurre	ed	
Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could I			e of Injury - At I ling, etc. <i>(Sp</i> ec		rm, stree	et, factory, of	ice		28	f. Location City or To	(Street own, Sta	and Numberate)	er or Ri	ural Route Number,
\sim		-		4			_									

State

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) Registrar

29a, Certifier

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland / I		irtment of F tificate of I			jiene leg. No.	2000	43370
Phys	icia		1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat Month	th Day	/ Year	3. Time of Death
-	dica		Aldine Edna	Powers					December		2009	11:30 a [™]
Exar	mine	r	4a. Facility Name (If not institution, give					Location of Death	1	4c.	County of Death	
			Carroll Hospice I		e (In yrs. last bii	thday)	Westmi	nster If Under 24 Hrs.	8 Date of Birth		Carroll	
Fune Direct	_		205-12-3427		84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 1925		lace (State or Foreign try) Sylvania
ryland how	ř		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				10	0d. Inside City Limits
e Ma 3a-f s			Maryland Worcest	er	Bei	clin	ı					1 ☐ Yes 2 🔀 No
章 or 2	1	Director	10e. Street and Number				10f. Zip Code		1	0g. Citi	zen of What Coun	try?
ath w s 23a	-	<u>a</u>	6554 South Point			_	2181				USA	
aryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Moute Examination that the modified at		by runeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □Yes 2⊠No	ispanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- Prican, etc.)		14. Race - Americ Black, White, e Specify:	etc.
2 hou			15. Decedent's Ed	ucation	16a	. Deced	ent's Usual Occup	ation		16b. Kii	nd of Business/Ind	nite Justry
Maryland 21215-0036 d 2 should be filed within 72 hours aft tith and Mental Hygiene. Z7 is marked other than "natural", or traumatic event, the Mondal Exp. of		Completed	(Specify only highest gra	de completed) College (1-4or 5-		(Give I life. E	kind of work done of OO NOT use retired	during most of work ()	king			,
21. giener far		Ş	Elonichiary/occordary (0-12)	5+	′	Regi	stered N	urse		Hos	pitals	
		8	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, I	Maiden	Surname)	
ylano buld be f Mental I larked of		2	Charles Dorato					Della	Unknown	1		
Aaryla 2 should b and Men is marker	2 1		19a. Informant's Name/Relationship (7	Type. Print)	19b	. Mailin	g Address (Street a	and Number or Ru	ral Route Number	r, City o	r Town, State, Zip	Code)
e, N 1 and 1 and Health em 27 ther tr		-	Charles J. Powers	son			Herbert .		stminste			
Baltimore, permit. Pages 1 ar Department of Hea Important: If item ?			20a. Method of Disposition 1 ☐ Burial 2 ☆Cremation 3 ☐	Removal from State	cemete	ry, crem	sition (Name of atory or other place	e) ∫a	դ. 1,		cation - City or To	
Iting it. Pa rtmer rtant		1	4 □ Donation 5 □ Other (Specify		Carro		remation		2010 I	Hamp	stead, M	aryland
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic er	once	П	21. Signature of Funeral Service Licen	see		22	Name and Addres	ss of Facility Prit	ts Fune	ral	Home and	Chapel, P
		+	23a. Part 1. Enter the disease, or comp	Signations that caused	the death. Do	4 <u>1</u>	2 Washing	gton Rd.	Westmir	nste	er, MD 2	1157 Approximate
	٥,		shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	e.	Mar.	a ne mode or dym					Interval Between Onset and Death
Physicia /Medic	_		disease or condition resulting in death)	a	ren	pr	TIL	118	CAN	VU		Jues
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68760 ificate be e g physiciar is the buria	i di	2		.d						_		
9 % F		2	IF FEMALE:									
death cert e attending d for use a	Maciologia (M		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal death	3 □	Ectopic pregnancy	/		2	23d. Date of delive	*
O. be the dear the a	13	2	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆	Other (specify)				Month	Day Year
P.C	40		Part II. Other significant conditions of	patributing to dooth bu	it not reculting in	tho un	dorlying on too give	on in Port I	22a Did tob	00000 11	se contribute to th	a cause of death?
dS, ires the signe d be c	Ž	2		No ben	Dile	O	denying cause give	mm ranti.	1 □ Ye			ably 4 ☐ Unknown
requestion in the contract of	100	י נונ		180 1 5	7.07				14	_/		
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VITAI ician: Tr certificate ector, pa			25 Man again referred to medical						1 □Yes 2	2 No	1 ☐ Yes	2 □ No
VIII sicia sicent lirectc	å	3	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	A [] ED/O	*****	2□ DOA Othe	26. Place of Deat			1-1-25/	11 U
VISION OF VITAI Attending Physician: It death. ector: After this certifica by the funeral director, p	115	- 10-	27. Manner of Death	28a. Date of Injur	nt 2 ER/Ou y 28b.	Time of	28c. Injury	4 □ Nursing Ho	ome 5 Reside		Other (Specify occurred	"
nding th.	1.5		1 Natural 5 Pending investigation	(Month, Day	(, Year)	njury	Work	? /es 2 □ No				
DIVISION I or Attending after death. Director: Afte	1	2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, fa	rm, stre	et, factory, office	= 1			d Number or Rura	l Route Number,
Lalor safte	Cortification.	3	4 I TOTALIO	building, etc	. (Opecity)				City or Town	i, State)	1	
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	legipo		29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best on liner: On the basis of and manner sta	examination an	, death d/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occur	, and due to the c red at the time, d	ause(s) ate and	and manner as st place, and due to	tated. the cause(s)
Nath of the same o	MA		29b. Signature and title of certifier	\ /			29c. License	6301)	2:	9d. Date	e signed (Month, L	Day, Year)
30	*	-	30. Name and address of person who o	ompleted cause of de	1 - <1	Type, F		wter in	721127	-/	10	
	State		31. Date filed (Month, Day, Year)	32. Registra				TO M	00			
Regi			JAN 0(4/	2010 Den	un &	. 1	bares					
DHMH 17 Bev	1/200		7		-	13						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Theodore Taft Parkinson, Jr. Month December 2009 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Ct. 1, 1930 Months 216-24-3972 1 2 M 2 - F 79 Yrs Maryland Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Anne Arundel Maryland Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 Rosecrest Drive 21403 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1XXYes 2 \(\square\) No or . Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1948–71 1 ☐ Yes 2XXNo Specify: Specify: Completed 3 - Widowed 4 - Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Attendant Mason's injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore Taft Parkinson Katherine Woodrow Monday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Parkinson/wife 118 Rosecrest Drive Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from Sta Hillcrest Mem. Gardens 12/27/2009 Annapolis, Maryland Donation 5 Other (Specify) ature of Fugeral Gervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition resulting in death) 2 days Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: ည 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical (29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Lawrence Jacobs

Box 68760

P.O.

Records,

of Vital

Division

person who completed cause of death (Item 23a) (Type, Print)

2009

2002 Medical Parkway

egistrar's Signature

D0062964

Suite 500

29d. Date signed (Month, Day, Year)

Annapolis, Maryland

December 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Paula Mary Frances Prahinski December 18, 2009 4:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis 2 Alden Lane Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F 215-38-3947 70 21, 1939 Washington, DC Jan. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 X Yes 2 No Director 10e. Street and Number 2 Alden Lane 10g. Citizen of What Country? 10f, Zip Code 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 📉 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Buyer Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Vincent Finegan Gladys Irene Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alden Lane Annapolis, Maryland 21401 19a. Informant's Name/Relationship (Type. Print) Arthur Prahinski/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Crematory 12/24/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature Transparal Savice Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** esophage sein /Medical Due to (or a sa conse and of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş cate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops performed 2 certificate 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: filled in by the funeral after death Director; within 24 hours a

To the Funeral C

completely filled To the

> 20 W

Medical

Registrar

State

29b. Signature and title of certifier

4 Homicide

29a. Certifier

and manner stated.

MD, MPH

29c. License number

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene St. Naomi Horiba, MD Baltimore, Maryland

31. Date filed (Month, Day, Year) DEC 28 2009



Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		se Type or Pri State of M							•		•	
	1 - For State Registrar		, , , , , , ,	-	tificate					Reg. No.	2000	4337
an/	1. Decedent's Name (First, Middle, Thelma C. Phipp	,							2. Date of Do Month	Day	y Year	3. Time of Death
cal ner	4a. Facility Name (if not institution,	give street and number)			4b. City,	Town, or	Location	of Death	12	/15/2 4c.	County of Dea	10:05 p ^N
	4570 Owensville				1611. 1		wood	0444			Anné Ar	
	212-82-8315	5. Sex 1 □ M 2√xF 7. Ag	je (In yrs. las 89		If Under Months	Days	Hours	Min.	8. Date of Bi (Month, D 10/5/			ountry) MD
ō	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Loc	cation	-						10d. Inside City Limits
Director		Arunde1		Наз	cwood							1 ☐ Yes 2 x(1x)
Funeral D	10e. Street and Number 4570 Owensville	Sudley Rd.			10f. Zip		2077	6		10g. Citi	izen of What C	ountry?
2	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces?		11	Yes, spec	ent of Hi ify Cuba	spanic Or n, Mexica	igin? (Spe ın, P uerto I	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi	te, etc.
sted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			☐ Yes			<i>/</i> :			Specify: W	hite
Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12)		5+)	life. DO	kind of wor D NOT use	k done d retired)		st of worki	ng		nd of Business	•
Be C	8 17. Father's Name (First, Middle, La	st)		НС	omema	ker	19 Moth	or's Name	(First, Middle		Own Hom	ie
얼	Charles Z. Catt	•							. Catte			
	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address	(Street a	ind Numb	er or Rura	l Route Numb	er, City or	Town, State, Z	ip Code)
	Gladys Wilde	Daughter		4570 ace of Dispos			.1e S		Rd.	T	ood, MI	
	1 🔀 Burial 2 🗆 Cremation 3 4 🗀 Donation 5 🗀 Other (Sp.		ce	metery, crem	natory or o	her plac		1/2/			st Rive	
	21. Signature of Funeral Service Lic		_ Our							unera	al Home	P.A.
	18- 2.Cf			-12	Rid	gely	_Ave	. Ar	napoli	s, MI	21401	
	23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	omplications that caused by one cause on each line. a. Due to (or as	e.			-			r respiratory a	rrest,		Approximate Interval Between Onset and Death
		Int	a conseque vacto	46 ha 1	Diai	the	Ο _λ					4 months
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as					-					
	Cause (Disease or iinjury that initiated events resulting in death) Last	c	a conseque	ence of):								
edical		d				<u>-</u>						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 [Ectopic p		у			2	23d. Date of de Month	elivery Day Year
by Ph	Part II. Other significant condition	s contributing to death b	out not resu	lting in the ur	nderlyin g o	ause giv	en in Part	1.	23e. Did	tobacco u	se contribute t	o the cause of death?
ted	Coronary	0	1200	ese					1 🗆	Yes 2	No 3 🗆 I	Probably 4 🗌 Unknow
Completed	Denentio	1							24a. Was auto perf		prior to	utopsy findings available completion of cause of
Be C	25. Was case referred to medical examiner?					26. Pla	ice of Dea	ath (Check		2 🖎 No	l 1 ∐ Ye	es 2 No
မ	1 Yes 2 No	Hospital: 1 Inpati 28a. Date of inju		R/Outpatien	$\overline{}$		4 L N				Other (Spe	cify)
icate	1 Natural 5 Pending 2 Accident Investiga	(Month, Da	y, Year)	injury	M 2	Bc. Injury work: 1 🔲			28d. Describe	how injury	occurred	
Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be		ne, farm, stre	et, factory	office		2	28f. Location (City or To		Number or Ru	ural Route Number,
Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e	xamination a	and/or investi	igation, in r	ny opinio	n, death o	ccurred at	the time, date	and place,	and due to the	cause(s) and manner sta
_	29b. Signature and title of certifier	Sierban	~.		29c.	License	number	~63			e signed (Mont	rh, Day, Year) - 18, 2500 V MD
												(
	30. Name and address of person w	no completed cause of d	eath (Item 2 عام 1	23a) (Type, Pi	rint)	4	17	0 1				Λ -

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43374 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month PATRICIA E. PASTORE 0200 1 28 Dec 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation + Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs fast birthday) Wicomico alisbun If Under 8. Date of Birth (Month, Day, Year) 8-5-1931 Sex 1 ☐ M 2 🗓 F 9. Birthplace (State or Foreign Months Days Hours PENNSYLVANIA Yrs 161-24-7956 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No DELAWARE SUSSEX BETHANY BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 WALKABOUT ROAD 19930 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 SCHOOL TEACHER - COLLEGE **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY PASTORE IRENE MONAHAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. HANNIGAN/ EXECUTRIX 318 WALKABOUT RD, BETHANY BEACH, DE. 19930 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State MELSONS CREMATORY 12/29/2009 FRANKFORD, DELAWARE 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun wal S 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. 38040 MUDDY NECK RD, OCEAN VIEW, DE. 19970 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. 23a. Part 1. Enter the dis-shock, or heart failer Approximate Interval Between Onset and Death Immediate Cause (Final 0 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, dur, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mor 1 □ Yes 2 No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 □No 2 2 100 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

P.O. Box 68760, Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura any injury or other traumatic event, Ir e Medical pages.

Physician

/Medical

Examiner

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funeral

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Funeral

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Be Completed

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Certification: To

Medical

3 Suicide

29a, Certifier

4 Homicide

(Check only

29b. Signature and title of certifie

death with the Marylan

1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by page 2 should be detact certificate this After t death. after death Director; i 24 hours after e Funeral Dire letely filled in b within 2

DHMH 17 Rev 1/2001

completely

State

Registrar

William H. Robins 31. Date filed (Month, Day) Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

6 ☐ Could not be

determined

32. Registrar's Signature

200

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

marks

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5, per ME g901 3/17/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** ^{Year} 2009 25, Betty Irene Long Runkles December 2:10 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 4100 Baptist Road Taneytown Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/06/1932 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director Unionville, 219-32-1320 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be retilized at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 X No Carroll Taneytown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 Baptist Road 21787 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: δ, Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Myrtle Viola Long ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Long - Son 11940 Martin Ln. Blue Ridge Summit, PA 17214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/28/2009 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Winfield, MD \$outh Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licensee 22. Name and Address of Facility M01191 Myers-Durboraw Funeral Home Soulow 21787 136 E. Baltimore St. Taneytown.
Do not enter the mode of dying, such as carding or respiratory arrest, MD 23a. Part . Enter the disease, or complications that caused the death. Approximate Interval Between immediate Cause (Final CINDM**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit EXAMINER Due to (or as a consequence of): CERTIFICATION Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) P.O. the detached 9 Unknown á signed of Pag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð this certificate has been s'al director, page 2 should 1 🗆 Yes 25 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 □ Ýes 1 ☐Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 **X**es 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. after death

Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifie icense number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMIN STEP. 10454F GAFFAR 555 MD SOUTH CENTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 28** 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Ter State of Maryland / I	Department of Health and N Certificate of Death	Mental Hygiene Reg. No. 200	3 43376
			Decedent's Name (First, Middle, Last)	- Certificate of Beatiff	2. Date of Death	3. Time of Death
	Physici /Medio	al	Daniel R. Reilly		December 29, 200	9 10:15am
. مد	Examir	er	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL	4b. City, Town, or Location of Death Silver Spr	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Bi	ntgomery rthplace (State or Foreign
	Director		081-44-0452	Yrs. Months Days Hours Min.	04/18/1952	New York
	yland how		10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	e Mai	Director	Maryland Montgomery	Silver Spr	ing	1 ☐ Yes 2 No
	with the		10c. Street and Number	10f. Zip Code	10g. Citizen of What C	ŕ
	death	Funeral	12779 Turquoise Terrace 11. Marital Status 12. Was Decedent Ever in U.S.	20904 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		S.A. erican Indian.
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, its "Madical Evan incr must be mailthed at	by Fu	1 ☐ Never Married 2 【X】 Married	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		te, etc.
Ö	hours itural"	ed b	3 Widowed 4 Divorced Year or Dates:	Decedent's Usual Occupation	Specify:	White
215	thin 72 ie. an "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing Tob. Kind of Business	s/industry
2	lled wi Hygier her th	Con	17. Father's Name (First, Middle, Last)	Agent	U.S. Gove	rnment
au	id be fi ental l ked of	To Be	Raymond Reilly	18. Mother's Name	ESTRELLA ORTIZ	
ary	2 shour and Mis mar	-		Mailing Address (Street and Number or Rur		Zip Code)
<u>ر</u> ه	s 1 and 2 of Health item 27 i			779 Turquoise Terrac		
nor	0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory`or other place)	Date 20c. Location - City or	,
Baltimore, Maryland 21215-0036	permit. Page Department Important: II any injury o	ĺ	4 ☐ Donation 5 ☐ Other (Specify) Gate 0 21. Signature of Funeral Stryke Ligensee	Heaven Cem. 12/37 22. Name and Address of Facility Hin	1/2009 Silver Spr	ing, MV
ñ	P P F F S		ours curan -	11800 New Hampshire	Ave., Silver Spr	ing, MD 20904
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
4.4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Respiratory Due to (or as a consequence of the consequence of			Offset and Death
	Examiner		Advanced Cin	<i>'</i>		
-	led isit	Examiner	if any, leading to immediate cause. Enter Underlying	1).		
, ,	execui n and al-tran	Exan	that initiated events resulting in death) Last c. Metastatic L Due to (or as a consequence of the conseque	iver, Lung Disease		
8/PU	icate be executed physician and s the burial-transit	dical	d. <u>Coagulopathy</u>			
ž X	ding pl	/Med	IF FEMALE:		=======================================	
20X	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	livery Day Year
7. O	at the	hysi	9 ☐ Unknown 9 ☐ Unknown	.,,,,,		
S.	ires th signec	2	Part II. Other significant conditions contributing to death but not resulting in Severe Ascites	the underlying cause given in Part I.	23e. Did tobacco use contribute to	
cords,	w requ	letec	Severe nacoces		1 Yes 2 No 3 P	-
ב	The la	Completed		<u> </u>	autopsy prior to performed? death?	utopsy findings available completion of cause of
112	nysician: The lis certificate hi director, page	Be	25. Was case referred to medical examiner?	26. Place of Death	1 □ Yes 2 🖾 No 1 □ Yes (Check only one)	s 2 No
5	Physical dire	ု	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of Injury 28b. T		me 5 Residence 6 Other (Spe	ecify)
20.5	nding ath. r: Afte e fune	atio		ime of 28c. Injury at york? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
2	r Atte ter dec irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,
ָׁ	pital cours af cours af eral D filled in					118
:	n 24 ho n 24 ho le Fun oletely	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge 2 ★ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, diversity of the control of the contr	and due to the cause(s) and manner a ed at the time, date and place, and due	s stated. e to the cause(s)
	To the Compt	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	th, Day, Year)
	6		by Mahmanica.	D66372	December	29, 2009
			30. Name and address of person who completed cause of death (Item 23a) (Maiid Rahmanian Shahri M.D. 15.		Silver Suring Ha	inuland anota
	Stat	~	Majid Rahmanian Shahri, M.D., 15. 31. Date filed (Month, Day, Year) DEC 31 2009 Alternative	La de la controla del la controla del la controla dela controla del controla de la controla de l	suver spring, Ma	regentin 20910
	Registra	r	UEC 31 2009 Cleans B. p.	pare		

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d, per DVR 9899 1/19/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Dorothy Dean Ross 1:01p. 28, 2009 /Medical Dec. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√ F Months Days Hours Min Yrs. 400-24-6341 Director 6/18/1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sl event, the Madical Examiner must be redtified Director MD Carroll 1 Yes 2 No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3820 Sunnyfield Court 21074 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: <u>۾</u> Specify: white 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the amy injury or other traumatic event, ITAL DIDE. 11 restaurant owner Dean's Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pleasant W. Copeland Maureen Taylor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Malone, daughter 832 South Main St., Hampstead, Md. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Hampstead Cemetery 12/31/2009 Hampstead, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 Handa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, long and the cause of the disease of the disease of the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, long and the death of the disease of the dis Approximate Interval Between Onset and Death Immediate Cause (Final 4 ASTRIC Physician CARCINOMA disease or condition resulting in death) OMONH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 □ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Sother (Specify) DOVE How 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 24 hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) the within To the 29b. Signature and title of certifier 29d. Date signed (Month Pay, Year) 29c. License number 12/29/000 K. Geleviota D31660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) manufact 21151 THOMAS K. GALVIN Wesomin STER 570 rec AUENUE IP 291 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 29 2009 Registrar Darke

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 William A. Russell Medical Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death HOSPICE Sbu com 0 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Washington DC 1 X M 2 □ F Months Days Hours Min 09/08/1930 Yrs. Director 577-40-4566 Usual Residence of Decedent 10b. County 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shortman or 23a or 25 Director 1 🗆 Yes 2 😾 No Maryland Worcester County Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Abbyshire Rd. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. 1948-52 Specify: White "natural" Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Baker Safeway Food Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 Is marked of traumatic ever ပ Stephen Allen Russell Lucy May Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trat once, 612 Admiral Dr., Irma Russell/ Daughter Apt. 383, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Veterans Cemetery 1/7/10 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 15 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any trading to in mediat cause. Enter Underlying Cause (Disease or iinjury Due to forms a consequence offs • Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: HOSPICE ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how inju Natural injury 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar

gx)

31. Date filed (Month, Day,

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733

BOX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#23A Per PHY State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 43379 State Registrar 12/30/09 AACO HEALTH DEPT. OMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Month 2009 26 9:05 A M Audrey Μ. Roberts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7964 Pipers Path Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2XXF Director 213-28-7399 Yrs. MD Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f shorexaminer must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7964 Pipers Path 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2x x No within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify White "natural", Specify: 3 XWidowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorris Kellum Drusilla Pickering 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Roberts Son 7964 Pipers Path Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 1/4/2010 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 17 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. LUNG CANCER Immediate Cause (Final CUI CON Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year be detached the Unknown g 🗌 Unknown g. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 🗌 No Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending nours after death.

neral Director: Aff
I filled in by the fur 1 Tes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tiple of certifier of death (Item 23a) (Type, Print) Tobrical of Gley Scinic art 2100 NEZ MU 31. Date filed (Month, Day, Year) State

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/24/2009 **Physician** ESTELLE CELESTE SUMMEROUR 12:55 A ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 907 North Stonestreet Avenue Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Director 80 215-44-4161 04/04/1929 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 XYes 2 No MD Montgomery Rockville 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 907 North Stonestreet Avenue 20850 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: Black <u>Ş</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) If Hygiene. Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Bus Attendant 10 Public School marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental James E. Summerour Essie Florence Ricks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 452 West Deer Park Road, Gaithersburg, MD 20877 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once. Vicki E. Summerour - daughter altimore. 20b. Place of Disposition (Name of centrellary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial ∠ Cremation Norbeck Mem. Park 12/31/09 Olney, MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Snowden Funeral Home №46 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** years Metastatic Preast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to jor as a consequence of be executed burial-tran resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical death certificate attending p for use as t IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö 9 Unknown signed by t I be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe certificate 1 ☐ Yes 2X No 1 ☐Yes 2 ☐ No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No r death. ours after death.

neral Director: /
filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/28/09 D37236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Dr, #506, Bethesda, MD 20817 MDCarolyn B. Hendricks, 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State DEC 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22, 2009 0100 Earl Clayton Selby December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4040 Rinehart Rd. Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 🔀 M 2 🗆 F Director 213-36-9610 Dec 19, 1938 Maryland Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City, Town or Location 10d Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Carroll Westminster 10e. Street and Number 10g, Citizen of What Country? ö items 23a 4040 Rinehart Rd. 21158 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed ar than "natur , the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than Janitorial Tevis Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Arthur Selby, Sr. Efie May Wentz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra Westminster, MD Ruth Selby Wife 4040 Rinehart Rd. 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem. 12/30/2009 Westminster, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 4 elek disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Box 68760, physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy perform 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | 1 | Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar orman

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

death (Item 23a) (Type, Print)

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Registrar's Signature

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For	State of Maryland / Department of Health and M	lental Hygic	men n	Q
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1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day	Vas

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			 Decedent's Name (First, Middle, La 	st)					2. Date of De		Vans	3. Time of Death
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j	/Medio Examir		4a. Facility Name (If not institution, given Carroll Hospital	-			4b. City, Town, or Local Westmins				nty of Death Carro	11
	Funeral Director			Sex 7. Ag	e (In yrs. last bir 71	thday)_ Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da Aug 29	th ay, Year) 1938	9. Birthp Cour Mary	place (State or Foreign ntry) Land
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	r dek tams	ne	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of Hispani Yes, specify Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.))- 14. Ra BI	ace - Americ lack, White,	
212-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show event, the Medical Examinar must be motified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 💢 ! If Yes, Give Year or Dates:	No	1		ecity:		i	ity: whi	te
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OUO	ng fter	on:	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. 1 <i>y Year)</i> I	Time of njury	28c. Injury at Work?		28d. Describe	how injury occi	ured	
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	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner sta	1100.		29c. License num	ber		29d. Date sign	ned (Month,	Day, Year)
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State Registrar

29b. Signature and title of certifier

| Nom | Linthum m. J. J. 0014317 | December 20, 2001

30. Name and address of person who completed cause of death (Mem 23a) (Type, Print)

| WILLIAM | K. LINTHICUM, M. A. ONE KINGS DRIVE, TANEYTOWN, M. D. 21787

31. Date filed (Month, Day, Year)

| DEC 28 2009 | Server | B. Jacks

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Tedford Lee Shenefelt 12:40 p^M December 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) Ctr. 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Health Care Carrol1 Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **3** M 2 □ F Months Days Hours Min. Director 193-28-8142 1922 87 Jan 04 PA Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 St. Mark Way #202 21158 USA filed within 72 hours after death v Hygiene. ither than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 □XYes 2 □ No 1942 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 □ Yes 2 □ 😿 Specify ģ Specify: 3 Widowed 4 Divorced 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Methodist Church Clergyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Ira Lee Shenefelt Pansye Rouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Shenefelt Wife 201 St. Mark Way #202 Westminster, MD 21158 permit. Pages 1 a Department of He Important: If item any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Greenmount Cemetery | 12/26/2009 | Hampstead, Maryland 21. Si partire of Fundial Service Licence Pritts Afunerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muscurl /Medical Due to r as a consequence of) Examiner 1 vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisass of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of) signed by the attending physician the detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) o the Hospital or Attending Plithin 24 hours after death. o the Funeral Director: After the ompletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) on, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number

To the I within 7 WIL 8

the death certificate be executed

Box 68760

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Records,

Division of Vital

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed ca

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Alexander Ber

31. Date filed (Month, Day, Year)

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ORIGINAL

3a) (T

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 43384 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bessie Samaras 2009 6:35 December Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center 4b. City Town, or Location of Death Examiner 4c. County of Death Anne Arundel Annapolis Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, eb. 27 235-30-7699 Months Days Hours 85 West Director 1924 Virginia Usual Residence of Deceden 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 23s or 28a-f show ofter than "natural", or items 23s or 28a-f show other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Unity Lane 21401 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Armed Forces Black, White, etc. ð 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 12 Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Genadopoulos Aphrodite (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George C. Samaras/son 300 Unity Lane Annapolis, Maryland 21401 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Demetrious Cem. 12/30/2009 Annapolis, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home T, West 147 Duke of Gloucester St., Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final Priysician Cneumom disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events om o (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? this certificate use Hospital or Attending Physician: The in 24 hours after death. 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes Other Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 \square Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical cutifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопріете (Check 3 🗌 To the P within 2. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertif Date signe

State

Name and a

'Date filed (Month

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who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 215 Edwin Sherman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/01/1930 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Hours Director 578-30-8735 Yrs. 79 NY Usual Residence of Decedent 23a or 28a-f show 72 hours after death with the Maryland the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 703 Capri Estates 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. 'natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1953 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Sales Industrial Chemical Salesman other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Theodore Sherman Florence Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Carla J. Sherman/Wife 703 Capri Estates Court, Arnold, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State injury (12/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Pk Sykesville, MD 22. Name and Address of Facility
Barranco & Sons, Signature of Funeral Service Licensee .A. Severna Park Funeral Ho wy, Severna Park, MD 21146 Hwy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner and I-transit The law requires that the death certificate be executed Due to for as a consequence of: resulting in death) Last signed by the attending physician a be detached for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performe autopsy death? After this certificate 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifice completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical (1 🖳 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

1. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 1640 /Medical December Frank A. Simmons 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arunde1 Anne Arundel Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Months Days Hours XXM 2□ F 1930 Maryland 79 **Director** Sept. 220-26-6923 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Lothian Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20711 1297 Marlboro Road permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23: any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify Black Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. ₽ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal 12th Printing Plant Worker yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christine Quander James L. Simmons Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1297 Marlboro Rd. Lothian, Md. 20711 Shirley A. Simmons (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 14☐ Eurial 2 ☐ Cremation 3 ☐ Removal from State Drury, Md. LOV Moses Cemetery 12/30/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wm. Reese & Sons MOrtuary, F 821 West St. Annapolis, Md. 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) U emons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 🗌 No | Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

31. Date filed (Mo

29b. Signature and title of

30. Name and address of per

Sarke

29d. Date signed (Month, Day, Year)

and manner stated

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or Pri	int in B	lack In	delible Ink	c. Ensure	All Copies	Are Legible	
		For State Registrar	State of M	laryland	/ Depa	artment of F tificate of D	lealth and i Death		ene2009	43387
Physicia Medic		1. Decedent's Name (First, Middle, I Cathreen Carric	,					2. Date of Death Month December	25, 2009	3. Time of Death 8:25 A ^M
Examin		4a. Facility Name (if not institution, g					Location of Death		4c. County of Dea	
Funeral		Crofton Convale 5. Social Security Number 6		er ge (In yrs. last	birthdav)	Crofton It Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne Aru	ndel thplace (State or Foreign
Director		577-56-5839 Usual Residence of Decedent	1 □ M 2 🖾 🍱 🖹	100	Yrs.	Months Days	Hours Min.	Feb. 1,	1909 Dece	mber 25,2009
Maryland 18a-f shov tified at	Director	10a. State 10b. County Maryland Anne Ar	runde1	10c. City, Crof	ton	cation				10d. Inside City Limits 1 → Yes 2 □ No
h the la		10e. Street and Number		•		10f. Zip Code		10	g. Citizen of What Co	ountry?
th wit ms 23 must	Funeral	2131 Davidsonvil			Lag	21114	1.011.040		U.S.A.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2凇No	n, Mexican, Puerto		14. Race - Ame Black, Whit Specify:	
nin 72 hour ne. than "natu e Medical	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12)	t grade completed) College (1-4 or		(Give k	ent's Usual Occupa kind of work done d D NOT use retired) essional ocalist	uring most of work	(ina	6b. Kind of Business	-
be filed witl ental Hygier ked other I ic event, th	To Be C	17. Father's Name (First, Middle, Las			V	ocalist	18. Mother's Nan	μ ne (First, Middle, Mi La Lucket		icner
12 should lith and Me 27 is mar r traumati		19a. Informant's Name/Relationship Sara S. Williams			19b. Mailin 2610	g Address (Street a Kresson	and Number or Rui	al Route Number, (City or Town, State, Zi	o Co <i>d</i> e) 115
age 1 and ant of Hea nt: If item y or other		20a. Method of Disposition **XX** Burial 2		cen	netery, crem	sition (Name of natory or other place			20c. Location - City or	
permit. P Departmo Importar any injur		21. Signature of Funeral Service Lic		Ft.L	22	. Name and Addres	s of Facility Ro	bert E.	rentwood, Evans Fune e, Marylar	eral Home
Physician/ Medical Examiner	iner	23a. Part 1. Enter the disease, or or shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	e. 2m	ent live	Fia			i. Discolar	Approximate Interval Between Onset and Death
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Medical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. ValV Due to (or as			Mean	J D	STOV		year?
the death cer by the attend ached for use	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal c	death 3	Ectopic pregnance Other (specify)	У		23d. Date of de Month	livery Day Year
requires that the de been signed by the should be detached		Part II. Other significant condition	s contributing to death t	but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
The law recate has be page 2 sho	Completed by		_	-				24a. Was an autopsy perform	ed2 prior to death?	ntopsy findings available completion of cause of
ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec	k only one)		
Physi this c	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat	ient 2 EF	R/Outpatien	t 3 DOA Othe	4 X Nursing H		oce 6 Other (Spec	cify)
ttending death. tor: After the fune	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	(Month, Da	ay, Year)	injury	M 1 🗆		28d. Describe hov		
pital or A ours after eral Direc		4 Homicide determin	building, et	c. (Specify)		eet, factory, office		City or Town,		
To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exa	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	examination a	nd/or invest	igation, in my opinio	n, death occurred a time, date and pla	at the time, date and ce, and due to the c	place, and due to the ause(s) and manner as	cause(s) and manner stated. stated.
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		30. Name and address of person whe Rakesh Arora M.I	·	•	, , , , ,	_{rint)} Lane Suit	te 222 Bo	owie, MD	20715_	
Stat Registra		31. Date filed (Month, Day, Year)		ar's Signatur	е					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND20b per FH State of Marylar state
Registrar AACO HEALIH DEPT. CMH 12/30/09 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22^{Day} Physician/ 1 Month 2009 Charlotte Stevenson 10:49 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 921 Eastham Court Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year 1/7/195 Days Hours Months 1 □ M 2 🖫 F 245-76-3752 Director 58 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2x No Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or dical Examiner must be Funeral 921 Eastham Dr. Apt.12 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1x Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes Give Black Specify: 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hv. Important: If Item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Stevenson Elizabeth Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Masters Dr. Blackwood, NJ 08012 Reginald C. Stevenson Brother 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State 12/30/09 cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 12/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Infa-cha disease or condition resulting in death) Cow Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Yes Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Heart Failue Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No has certificate 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital ည 1 Inpatient 2 ER/Outpatient 3 IDOA this Within 24 hours after usa...

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 034543 ann

Registrar
DHMH 17 Rev 7/2009

State

Mothic

31. Date filed (Month, Day, Year)

6

Baltup W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASTING

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State of Maryland / Department of Health and Mental Hygien 1 - State Amend Item 21 per fhmg899,01/19/10dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Physician SOLIDAY 12:55 P™ **FLORENCE** L. DECEMBER 31. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ELKTON CARE AND REHABILITATION CECIL ELKTON CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Months Days 1 □ M 2 🛣 F Yrs 87 203-07-8347 8/19/1922 PENNSYLVANIA **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD CECTL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 by Funeral PRICE DRIVE UNITED STATES filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental H ant: If item 27 is marked ott Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ဂ CHARLES BOLTZ MABEL SCHAUER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS S. SOLIDAY/SON 151 WALKER RD LANDENBERG, PA 19350 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition GRACELAWN MEMORIAL PARK 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2010 NEW CASTLE, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SPICER-MULLIKIN FUNERAL HOME DVR JOHN E. MEYER per 1000 N DUPONT PKY NEW CASTLE, DE 19720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DECUBITUS ULCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş PARKINSON'S DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P.V. Nagu 70 Doo6 5733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKIDN MD-21921 126 A E. H76H PULL Smeet V-NARAJANA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Dec. 30, Dwight Street 13:17 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Center Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🔀 M 2 🗆 F 72 Months Days Hours Year Director 246-52-0132 Aug. 1937 Usual Residence of Decedent ii Hyglene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 Kerby Hill Road 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify If Yes, Give Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Sexton Religious traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဥ Unknown Rosetta Street permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerby Hill Road. injury or other Fort Washington, MD 20744 Margaret E. Street -20a. Method of Disposition Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 1/6/2010 Brentwood. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bell & Johnson Funeral Home, P. A. udith 6503 Old Branch Ave. Temple Hills, MD 20748 23a. Fay 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate rval Betwee Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) Medical Due to (br as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate 2 🗆 No Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 2 3 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Watural 5 Pending 24 hours after death. Funeral Director: Af Accident 1 Yes 2 🗌 No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыет Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 3 Certifying Nase Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of

DHMH 17 Rev 7/2009

32. Registrar's

		State of Maryland / Department of Health and M 1 - State Registrar State of Maryland / Department of Health and M Certificate of Death		giene Reg. No. 20 (9 433	391
		- nogoral	2. Date of Dea	th	3. Time of D	Death
Physicia		Beverly Ann Segeniewkz	ecembe		09 4:20 I	РМ
/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of	Death	
		9115 Old Marlboro Pike #1A Upper Marlboro			George's	
Funeral			8. Date of Birth (Month, Day		 Birthplace (State or Country) 	Foreign unk
Director		370-36-1336	May 24	, 1944		
and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City	y Limits
Mary -f she	ğ	MD Prince George's Upper Marlboro			1 ☐ Yes	2∏ No
r 28a	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, I as the died Exantinates in cities at	Funeral Director	9115 Old Marlboro Pike #1A 20772		USA		
deatl	ner	11. Marital Status Unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spelfres) If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race -	American Indian, White, etc.	
after or ite	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Specify:	iloan, etc.)	Specify:	white	
ours rral",	d by	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:	are to			unk
72 hours "natural",	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work dane during most of working the DOMOT was desired as a complete of the DOMOT was desired as a com	unk	16b. Kind of Busin	ness/Industry	unii
within sne.	d m	Elementary/Secondary (0-12) College (1-4or 5+) unk				
filed v Hygid ther	ပ္သ	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name	(First, Middle,	Maiden Surname)		unk
d be ental ked o	To Be					
shoul nd M mar	E)	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura	I Route Numbe	er, City or Town, St	tate, Zip Code) U	nk
nd 2 alth a 27 is r trau		Prince George's Police Dept				
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natur any Injury or other traumatic event, it is inverient once.		cametery cramatory or other place)	ate	20c. Location - Ci	ity or Town, State	
Page nent c		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) in State				
mit. partn porta / Inju		21. Signature of Euperal Service Licensee	655 W.	Baltimo	re Street	
B a a a b d		Ronald 8 Wader Prector State Anatomy Board Baltimore, MD 2120				_
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac on hock, or heart failure. List only one cause on each line.	r respiratory ar	rest,	Approximate Interval Betw	veen
Physician		Imme Nie Cause (Final disease - dition resulting in death) a. Attroop Control Ref		122221	Onset and D	eath
/Medical		resulting in death) Due to (or as a consequence of):	7			
Examiner	L	Sequentially list conditions.				
ed sit	Examiner	if any, leading to immediate Due to image as a consequence of):				
and tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
cate be executed physician and the burial-transit		Smaking				
	dical	d. Sours letter				
Attending Physician: The law requires that the death certif roteath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	MY.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date	of delivery	
death atte	Physician/M	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Mont		'ear
the oy the	hysi	9 □ Unknown				
s that	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contrib	oute to the cause of de	eath?
quire en sig uld b		Suspected Penperal Arteritis	11	es 2□No 3	B ☐ Probably 4 ☐ U	Inknown
aw re	olet		24a. Was		ere autopsy findings a	available
The late ha	Completed			rmed? de	ior to completion of ca eath? ⊒Yes 2 ⊒No	iuse oi
ian: rtifice tor, p	Be C	25. Was case referred to medical 26. Place of Death				
ding Physician: The law requir h. After this certificate has been s funeral director, page 2 should		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Resid	dence 6 Other	(Specify)	
ng Pł	L:uC	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	t	
endil sath. or: A he fu	atj	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
or Att fter d irect n by	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28el Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Toห	Street and Number vn, State)	r or Rural Route Numi	ber,
oital ours a urs a sral D		CON Contillation Will Build To the Land of		(.)		13
Hosp 24 ho Fune stely f	lica	29a. Certifier (Check only one) 2	and due to the ed at the time,	date and place, ar	ner as stated. Ind due to the cause(s))
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)	
F ≥ F ŏ			_	1-5	-10	
		30. Name and address of piec in who completed cause of death (Item 23a) (Type, Print)	ا(کہ د	. 0-	A lot 15	Pind 113
		Eucere Teal of 1459 Made Son Rd	Sout	Th 00	no 75	SYI
Sta	te	31. Date filed (Month, Day, Year) . 32. Registrar's Signature		¥ 1	00 00	: 1-20
Registra		JAN 15 2010 Lener A. Janes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		irtment of H <i>tificate of I</i>			jiene _{leg. No.} 2	43392
			1. Decedent's Name (First, Middle, Last)			2. Date of Dec			th	3. Time of Death
	Physicia /Medic		December 4.3. 4007						9 6:15 PM™	
4	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							
			7815 Ballston 1	Baltimore			Baltimore			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show of any injury or other traumatic event, the Medical Examiner must be notified at once.		5. Social Security Number 220–20–3928 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IM 2FF	yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov 25,	1928 Ma	rthplace (State or Foreign ountry) ryland
			Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Loc	cation				10d. Inside City Limits
		5								1 □Yes & □ No
		To Be Completed by Funeral Director	MD Baltimo:	re	Ба	11timore		1	log. Citizen of What C	ountry?
			7815 Ballston Road	1		2120	4		USA	
9				12. Was Decedent Ever Armed Forces? 1 □Yes 2 No If Yes, Give		Uwas Decedent of H f Yes, specify Cuba □ Yes 2\No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
215-0036			3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a, Deced	dent's Usual Occup	ation		16b. Kind of Business	
			(Specify only highest grad	Collegg (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired) public relations			ing	non profit	
land 2			17. Father's Name (First, Middle, Last) Robert J. Nichols	18. Mother's Name <i>(Fin</i> Margaret				st, Middle, Maiden Surname) Luckett		
≥			19a. Informant's Name/Relationship (Type. Print) C. Herbert Sadtler/spouse 19b. Mailing Address (Street and Number of Rural Boute Number, City or Tawn, State, Zip Code) 7815 Ballston Road Baltimore, MD 21204							Zip Code)
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☒ Donation 5 ☐ Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date	20c. Location - City o	r Town, State
Balt			21. Signature of Euroceal Corvice Licensee Ronald'S Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
	Physician: The law requires that the death certificate be executed By A By The State of the stending physician and Bost of the attending physician and Bost of the attending physician and Bost of the stending physician and Bost		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
			shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition a Cancer Another Cancer Months							
£'			resulting in death)		Due to (or as a consequence of):					D FROM NO
		Examiner	Sequentially list conditions	h						
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	Due to (or as a consequence of): Due to (or as a consequence of):					
		хаш	that initiated events resulting in death) Last	Due to /or as a cor						
68760,		by Physician/Medical		Duo 10 (01 40 4 001						
387				d						
O. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ Unknown						23d. Date of delivery Month Day Year	
ds, P.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown	
of Vital Records,		Completed				-		24a. Was a	an 24b. Were	autopsy findings available
Ä	The lav	mo;						autop: perfor 1 □ Yes	med? death?	o completion of cause of es 2 □No
ita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Be C	25. Was case referred to medical 26. Place of Death (Check only one)							
<u></u>		Medical Certification: To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
Division o			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	tition (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office 28f. I			28d. Describe h	8d. Describe how injury occurred		
			3 Suicide 6 Could not be determined				28f. Location (S City or Tow	Location (Street and Number or Rural Route Number, City or Town, State)		
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
_	Vith Vith Com								29d. Date signed (Mo.	
			ding to	25 MD		D4	6988		1-08-	2010
			30, Name and address of person who completed cause of death (Item 23a) (Type, Print) RIMA COUZI; 7501 OS CER DRIVE, TOWSON, MD 21204							
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 5 2010 Lever A. Fegistrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Registrar

Certificate of Death

Reg. No. 43394 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2009 14 M Sar barra unev Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death vicomico Peninsula Regional medical conte 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Hours Country) Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 heavy injury or other traumatic event. 10a. State 10b. County ← → K 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Quantic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21856 AZL 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 - Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ rnev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 21856 S Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date JUK 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation_5 ☐ Other (Specify) Sign for of Furtheral Service Ligens 18434 22. Name and Address of Fallity PA 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Die to for sea consequence as 2 Approximate Interval Between Onset and Death Physician/ Medical Examiner subdura Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and dedected for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Director: After this certificate has autopsy performed? Yes 24 No within 24 hours after death.

To the Funeral Director: After this certificd completed filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury **ForMid**^h, Day, Year) **12/22/2009** Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 - Pending 2 X No Multiple falls Unknown M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Home 28f. Location (Street and Number of Rural Route Number, City or Town, State) Found: 26059 Nanticoke Road, Quantico,MD Homicide determined Medical Nying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Lead to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

290 Hoense number

290 Hoense number nly one 190. Late signed (Month, Day, Year) inat re D57331 MID son who completed cause of death (Item 23a) (Type, Print) 30. Nan Carroll St. Salisbury MD 21801 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1620 Richard Tilghman 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Pcninsula Modical Conto coima 8. Date of Birth If Under 1 Year If Under 24 Hrs Funeral Birthplace (State or Foreign Months Days 1 X M 2 🗆 F 09/18/1970 216-90-3736 Maryland Director 39 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 XYes 2 No Maryland Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7543 Pauls Place 21874 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: white Completed 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) automotive technician Race Track Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert L. Tilghman Sr. Jackie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7543 Pauls Place, Willards, MD 21874 Gwen Tingle/fiancee 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhill Menory 1/4/2010 4 Donation 5 Other (Specify) Hebron, MD Gardens . Signature of Funeral Service License Name and Address of Facility HOLLOWAY Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final an Ch. aucreatil Pnysician/ MIGHISTANO Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it says to be cause. Enter Underlying Examiner Due to or as a consquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE sate has been signed by the attendir page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 A After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1.X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature title of certifier 166198 of person who completed cause of death (Item 23a) (Type, Print) St SAlisbury md 21801

Registrar DHMH 17 Rev 7/2009

State

1008

MD

DHMH 17 Rev 1/2001

Registrar

-5 2010 ▶

State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 21, **Physician** December 2009 1:48 Betty Dixon Vance /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/03/1929 **Funeral** Days Hours North Carolina 1 ☐ M 2 🕱 F 241-42-8385 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County show traumatic event, the "Actinal Examiner nust be notified at 1 ☐ Yes 2 No Director Anne Arundel Riva Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or USA 21140 114 Ridge Road by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Cameron Clifton Nash Dixon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Ridge Road, Riva, MD 21140 Lesley Vance - Daughter permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other i once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oleander Mem. Gardens 12/30/2009 Wilmington, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Inc 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Concer Lurch reost /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burlal-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4★ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 propatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12-21-2009 - mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson Kobert MI> 31. Date filed (Month, Day, Year) 32. egistrar's Signature State

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

DEC 28 2009

2. Pegistrar's Signature

Drewn B. Janes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 9 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Linda C. Williams December 30, 2009 2:13 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 15100 Interlachen Drive, Apt. 926 Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. (Month, Day, Year) March 21, 1922 295-18-1137 87 **Director** Ohio Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🎦 No Maryland Mon topmery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15100 Interlachen Drive, Apt. 926 20906 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates. Black, White, etc. ρ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည be 1 Pietro Ciarrochi Lucia Lance permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Williams/Husband 15100 Interlachen Drive, #926, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 The Removal from State Jan. 2 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, VA 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Francis J. Collins Funeral Home Inc. Authorization Spring, MD 20901 21. Signature of Funeral Service License 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 🗌 No 2 🔀 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 🗽 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

To the 10

Accident

30. Name and address of person Joseph Kaplan, MD 31. Date filed (Month, Day, Year)

Investigation

Certificate: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of cartifie 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) d35635 December 30, 2009

1 ☐ Yes 2 ☐ No

State Registrar Registrar's Signature garren

who completed cause of death (Item 23a) (Type, Print)
18111 Prince Philip Drive, Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PI, line b-c, 26, 27 per ME 8901 3/19/10 TT Amend Items 23,26,27,28b,c per me, 8899,01/19/10dhbygiene For State Registrar 43399 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/27 Cavanaugh Wright Jr. /2009 0120 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 - F Hours 09/25/1947 Maryland Director Yrs. 212-54-2178 62 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d, Inside City Limits Directo 1 Yes 2 No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4606 Woodfield Rd. 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ည Ralph C. Wright Grace Elizabeth Voland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid M. Sunzenaur- Wife 4606 Woodfield Rd. Bethesda MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chespeake Crematory 12/30/2009 4 Donation 5 Other (Specify) Bethesda, MD 21. Signature of Funeral Service Lige 22. Name and Address of Facility 933 Gist Ave. Stole Dollar Rapp Funeral & Cremation Ser. Silver Spring 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Subdural Hematoma Medical Due to (or as a consequence of) Examiner Fo11 Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury Cardia Arrest anding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnan 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year the the 9 Unknown The law requires that the P.O. been signed by 1 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has autopsy performe death? certificate 1 Yes 2 No ☐ Yes 2 No Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?; 1 Yes 2 No Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of **Unk** 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 12/12/2009 12/5/2009 Natural Accident 5 Pending work Traumatic Fall, Head Trauma -0388 24 hours after death.

Funeral Director: A 2 🛚 No 1 Tyes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Hospital Home 4606 Woodfield Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature a d title of certific 10 29d. Date signed (Month, Day, Year) MD,Y MD 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd. Bethesda MD 20814 Donald Shields MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 19 2010 Registrar

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Physician /Medical Examiner

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Division or Vital Records, P.O. Box 68760,

Physician

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Examiner

Funeral

Director

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Department of Health at Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

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disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

Dement! a

Recurrent

of legs

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 Yes 26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

25. Was case referred to medical examiner? 20010 1 Tes

> 5 ☐ Pending investigation 6 Could not be determined

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Voluming Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

0002835

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

WEIL & LATTIN 101 COLONIAL 31. Date filed (Month, Day, Year) JAN 0 5 2010

32. Registrar's Signature

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death between 08304-5 PM Month Year 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death EIK Neck Elkiton Ceci Koad 8. Date of Birth (Month, Day, Year)
Sept. 15,1928

9. Birthplace (State or Foreign Country) pland Pennsylvania If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 17 F Months Days Hours Min. 211 22 4943 Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 Butterfield Lane 21901 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paramedic **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Weary Gladys Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Wriston / Granddaughter 3352 Old Elk Neck Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 31, 2009 Mayerdale Crematory Newark, Delaware Service Lind 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final minutes muthmic disease or condition resulting in death) Due to (or a la consequence of): disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an COPD 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 W Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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Completed

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Funeral

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7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If Item 27 Is marked other the any injury or other treamment.

72 hours after death

Maryland 21215-0036

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Examine Physician/Medical þ Completed Be Certification: To

requires that the death certificate be executed attending physician for use as the buria signed by the at be detached f Ö Records, cate has by page 2 s Hospital or Attending Physician: The certificate Vital director, Division of this funeral After death. n 24 hours after death.

Funeral Director: A sletely filled in by the fu completely

To the within 2.

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

 W_{\cdot} /// 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene and a

2102

Physici /Media Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical East of the traumatic area once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

WII Sta Registrar

	1 - State Registrar	C	Certificate of	Death	, 0	g. No.	9 43402		
an	1. Decedent's Name (First, Middle, Last) Frank W. Wedeking		_		2. Date of Death Month Decembe:	Day Ye	3. Time of Death		
al er	4a. Facility Name (If not institution, give street and Long View Nursing Home		4b. City, Town, o	r Location of Death		4c. County of D			
	5. Social Security Number 6. Sex 1 M M 2 □ F	7. Age (In yrs. last birtho	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr.	9. 1923 Wi	Birthplace (State or Foreign Country) LSCONSIN		
ctor	Usual Residence of Decedent 10a. State Maryland Carroll Count	10c. City, Town c Hampste					10d. Inside City Limits 1 □ Yes 2 📉 No		
al Dire	10e. Street and Number 4204 Black Rock Road		10f. Zip Code 21074			nited Sta			
Be Completed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 If Yes,	s 2 No 1 Jaja	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🏋 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. white		
Complete	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) 12 College	d) e (1-4or 5+) Buil	decedent's Usual Occup Give kind of work done lia DO NOT use retire ding & Gro erintendent	during most of wor	king	6b. Kind of Busine Facility Maintenar	•		
To Be (17. Father's Name (First, Middle, Last) William C. Wedeking			18. Mother's Nam	ne (First, Middle, M Smith	aiden Surname)			
	19a. Informant's Name/Relationship (Type. Print) Gary F. Wedeking — son	1	Mailing Address (Street 19 Raintree		Westmins	ter, Mary	yland 21157		
	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of D cemetery, Carroll	isposition (Name of crematory or other pla Cremation	i Dec.	20	Oc. Location - City Hampstead	orTown, State d, Maryland		
	21. Signature of Funeral Service Ligensee	M01072	22. Name and Addre 934 South	ess of Facility $ {f E} {f I}$	ine Fune		aryland 21074		
iner	resulting in death)	at caused the death. Do no no neach line. The state of the death of the death. Do no no neach line.	Artery	ng, such as cardiac		st,	Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to himsolate cause. Enter Underlying Cause (Disease or injury		24						
Medical Examiner	that initiated events resulting in death) Last c	to (or as a consequence of)	ence of):						
Completed by Physician/Med	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal death egnant at time of death iknown	3	Sy		23d. Date of Month	Bd. Date of delivery Month Day Year		
ed by Pr	Part II. Other significant conditions contributing to	death but not resulting in the	he underlying cause giv	en in Part I.	23e. Did tob	Au	te to the cause of death? Probably 4 Unknown		
Complet		•			24a. Was ar autopsy perform 1 🗌 Yes 2	/ prior			
Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA	or: AA	th (Check only one ome 5 ☐ Reside		Specify)		
Medical Certification: To	Natural 5 Pending (N 2 Accident investigation	te of Injury 28b. Tin	ury Wor M 1 □	ry at k? Yes 2 ∐No	28d. Describe ho		Court Parts Number		
l Certif	4 Homicide determined	ice of Injury - At home, farm		ime data and ulas	City or Town	, State)	r Rural Route Number,		
Medica	29a. Certifier (Check only one) 2 Medical Examiner: On the and m	the best of my knowledge, or e basis of examination and/anner stated.	death occurred at the tool or investigation, in my	opinion, death occu	rred at the time, da	ause(s) and manner ate and place, and Od. Date signed (M	due to the cause(s)		
	Deaning, 1	NY	\mathcal{D}	51705	5	12-28	-09		
	30. Name and address of person who completed on the state of the state	349 Mala	W(m DR	, Nest	minst	er, Mr	21157		
te ar	31. Date filed (Month, Day, Year) 32 DEC 2 9 2009	Registrar's Signature	backer						

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital Records,

Division

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

DEC 28 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KicketTS MI)

32. Registrar's Signature

ORIGINAL

200 Memorial, Ave

MINS

			For State	State of Ma	ryland / Dep	partment of h	lealth and N	/lental Hyg	iene	1 - 0 !
			Registrar 1. Decedent's Name (First, Middle)	le, Last)	<i>C</i> (ertificate of	Death	2. Date of Deat	eg. No 2009	3. Time of Death
	Physic /Medi		MARY	M		WILL	1 Ams	Month 12	Day Year	
	Exami		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	
-		P	Mandrin Chesar 5. Social Security Number			Harv			Anne Arur	
	Funeral Director		578-38-5796	6. Sex 7. Age	(In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/17/1	9. Bi 929 Was	irthplace (State or Foreign Country) Shington, D.C.
	pu ≥ ∷		Usual Residence of Decedent					127 177 1	713 Max	
	Maryla f sho	ō	10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-	irect	MD Anne 10e. Street and Number	Arundel	Annapol	1.S 10f, Zip Code			0g. Citizen of What C	
	th with 23a o	Funeral Director	970 Riversedge	Circle		21401			USA	•
	er dea tems	nuei	11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
336	irs afte	by F	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	If Ves Give		1 □Yes 2X No	Specify:	,	Specify:	White
2-0	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evaminer must be notified at	ed	15. Deceden	t's Education	16a. Dec	edent's Usual Occup	ation		16b. Kind of Business	
21215-0036	vithin 7	Completed by	Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+))	e kind of work done of DO NOT use retired	furing most of worki ()	ing		
d 2	filed v Hygic other i	ပိ	12 17. Father's Name (First, Middle,	Last)	H	omemaker	18. Mother's Name	(First Middle N	Own Home	
/lan	uld be Venta Irked o	To Be	Clarence Richar	d Winemiller			Margaret		*	
Man	2 sho 2 sho and l is ma rauma		19a. Informant's Name/Relations					al Route Number,	City or Town, State,	Zip Code)
ė,	is 1 and 2. of Health a item 27 is		Richard F. Will 20a. Method of Disposition	iams / spouse		Riversedo			olis, MD 2	
HOL	Pages ment of ant: If its	l li	1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			position (Name of ematory or other place			20c. Location - City or Brentwood ,	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaniner mast be notified at once.		21. Signature of Funeral Service		TOTE HILL	22. Name and Addres	ss of Facility Bea	all Fune:	ral Home	ן כוואן
<u> </u>	6 9 E 8 9	. 15	1//1	2	10.0	6512 NW Cr	ain Hwy.	Bowie	e, MD 207	15
				complications that caused the only one cause on each line	he death. Do not ei	nter the mode of dying	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or on a	consequence of):	Ac				month.
	Examiner		Conventingly, list conditions	b	consequence or).					
	led isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	consequence of):				102	
<u>,</u>	execut n and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
8760,	certificate be executed rding physician and se as the burial-transit	ical		d						
Ö	certifica ding pl	/Med	IF FEMALE:	20. 16				=72		
Box	atter for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year
д. О	at the c by the tachec	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 🗆 Unknown						
	res the signer be compared to the compared to	ρ	Part II. Other significant condition	ns contributing to death but	not resulting in the t	underlying cause give	n in Part I.			o the cause of death?
Records,	v requ been should	eted						-		robably 4 hknown
	e 2	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
/ital	ilclan: The certificate ector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes 2 (Check only one		s 2 No
5	this all dir	욘	1 Yes 2 No 27. Manner of Death		2 ER/Outpatie		4 LI Nursing Hor	ne 5 ☐ Resider		ecity) H. Cour
\subseteq	ng ifter	ţi	1 Natural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day,)	(ear) 28b. Time of Injury	Work	at ? 'es 2 ⊡No	28d. Describe hov	v injurý occurred	Hyeles
DIVISION	r Atter er dea rector by the	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be	- At home, farm, st				eet and Number or Ri	ural Route Number,
5	oital or urs aft eral Di	O						City or Town,	,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best of a Examiner: On the basis of examiner and manner state	xamination and/or it	th occurred at the tim rvestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
	To th within To th comp	§ ≧	29b. Signature and title of certifier	1	_ /	29c. License		29	d. Date signed (Mont	th, Day, Year)
		ľ	TOU	O CAE	Thun		2143	8 1	scenh	222009
	130		30. Name and address of person v	1 CHENTY	un ilili	Print) DEFE	ENSEH	16+WA	MANNA	222009 POLIS MORIVE
İ	Stat Registra	٠	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	backer		-1.		
	negistra	"	DEC 2	8 2009 Kene	me for I	7				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRANK EUGENE WADSWORTH DECEMBER DECEMBER ^{Day} 26 2009 10:22A. M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death 88 HARBOUR HEIGHTS DRIVE ANNE ARUNDEL ANNAPOLIS If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 😿 M 2 🗆 F Days Months Hours Director SEPTEMBER 20, 1926 CALIFORNIA Yrs 83 515-14-9440 Usual Residence of Decedent show 10a. State 10h. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MARYLAND ANNE ARUNDEL 1 Tyes 2 No ANNAPOLIS 10e, Street and Number 10f. Zip Code other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Importants If free 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must b. Funeral 88 HARBOUR HEIGHTS DRIVE 21401 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ed Forces þ 1 Never Married 2 X Married 1 X Yes 2 No WORLD
If Yes, Give
Year or Dates. WAR I Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: WHITE WAR II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working COMMERCIAL Elementary/Seconday (0-12) College (1-4 or 5+) 4 SALESPERSON REFRIGERATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FRANKLIN WADSWORTH HELEN PALMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA J. WADSWORTH/WIFE 88 HARBOUR HEIGHTS DRIVE, ANNAPOLIS, MARYLAND 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION DECEMBER 4 ☐ Donation 5 ☐ Other (Specify) 2009 STEVENSVILLE, MARYLAND
22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM
CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE
ROAD, ANNAPOLIS, MARYLAND 21401 CENTER 21. Signature of Funeral Servicesicenses Will El Soun M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition CARDIAC ARRHYTHMIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury tran that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year the a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has performe certificate ☐ Yes 2 🗖 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at After 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determine 28f. Location (Street and Number or Rural Route Number, Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 3 Certifying within 2 To the I 29b. Signature and title of 30. Name and address of completed cause of death (Item 23a) (Type, Print) Aditua 600 31. Date filed (Month, Day, Yea Registrar's Signature State 30 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Month Year Jeffrey Allen Wiseman 9:10pM 12 2009 /Medical 30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital Elkton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/17/1965 **Funeral** Hours Days 1 € M 2 □ F 44 Director 213-78-0542 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "modical Examinating at Director 1 XYes 2 No MD Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 21901 22 N. Main St. Funeral Apt 1 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ā Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No <u>≽</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Helper Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn Palmer Wiseman Frances Anne Purner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Reese/ sister 359 Old Chestnut Rd. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/4/2010 permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, MD 22. Name and Address of Facility 21. Signature of Funeral Service R.T. Foard and Gee 259 E. Main St. Elkton, MD 21921 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Ca. (Final Approximate Interval Between Onset and Death **Physician** Due to for as a consequence of). tellive disease or condition resulting in death) /Medical Examiner Aspiration premonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequen of): the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) and Cerebellar physician ar P.O. Box 68760 Physician/Medical as attending IF FEMALE use 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) the □Yes 2□No 9 Unknown þ or Attending Physician: The law requires that s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has s 24a. Was an autopsy performed?

1 □ Yes 2 🕅 No page certificate 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of 1 ☐ Yes 2 📉 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address the erson who complete cause of death (Item 23a) (Type, Print) 06 Street Bow 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra JAN 0 4 2010

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

JAN 04

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ORIGINAL

un Sr. MD

32. Registrar's Signature

ester RI Monchester und 2119

			1 - State of Maryla		artment of I		nd Me		ene g. N2 0	09	43408
7	Physic /Medi		1. Decedent's Name (First, Middle, Last) Selma		Alden			Date of Death Month ecember	Day	2009	3. Time of Death 10:20 Р м
-	Exami	ner	4a. Facility Name (If not institution, give street and number) 3142 Gracefield Road #MG609 5. Social Security Number 6. Sex 7. Age (In vr.	s. last birthday)	4b. City, Town, of Silver If Under 1 Year	Spring	g	D. 1. (Pin)	4c. Count	ty of Death	
	Funeral Director		144-12-9516 Usual Residence of Decedent	Yrs.	Months Days		Min. 12	Date of Birth (Month, Pay, 2/20/19	Year) 24	9. Birthp Cour New	place (State or Foreign htry) Jersey
	the Marylar 28a-f show relitied at	Director		ity, Town or Lo				10	g. Citizen of		0d. Inside City Limits 1 Yes 2 No
	s 23a or		3142 Gracefield Road #MG609		20904				United		ŕ
9800	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be rediffied at	d by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cub I □Yes 2 🛛 No		i? (Specif uerto Ric	y Yes or No- an, etc.)		ice - Americ ack, White, e ify: Whi	etc.
Baltimore, Maryland 21215-0036	d within 72 h giene. er than "natu ire Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire omemaker	pation during most of d)	working		6b. Kind of B		dustry
and	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) Samuel Maurer			18. Mother's		irst, Middle, Ma			
ary	12 should be fi h and Mental H r is marked ot raumatic ever	2	19a. Informant's Name/Relationship (Type. Print)		g Address (Street	and Number o	or Rural R	oute Number,			Code)
re, r	s 1 and 2 of Health item 27 i	2000	Joan Alden – daughter 20a. Method of Disposition 20b.	1	Overlea sition (Name of		Rocky		D 2085 Dc. Location		wn, State
ti mo	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.				sition (Name of natory or other place ham Memo ark		12/31	1/2009	Union	ı, NJ	,
Ва	perm Depa Impo any i		21. Signature of Funeral Service Licenses M01163	- Ec	Name and Addre	ss of Facility e1 Fune kville	eral Pike	Direct Rocky	ione I	£ 208	52
The state of the s	Physician / Medical Examiner Stre parial-transit	al Examiner	23a. Part I. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atheroscl Due to (or as a consect of the conditions) of the conditions of	erotic quence of): n quence of):	Cerebrov				t,		Approximate Interval Between Onset and Death
/20)	ertificate ing phys e as the	Medical	d. Chronic S	evere i	alli						
. O. Box	ine death certification is the attending packed for use as the section is the action is action.	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □	Ectopic pregnanc Other (specify) _	у				ate of delive onth	ry Day Year
cords, r	requires tha een signed nould be det	0	Part II. Other significant conditions contributing to death but not res	ulting in the un	derlying cause give	en in Part I.					e cause of death? ably 4 🗌 Unknown
וומו חפני	afficate has b or, page 2 sl	e Completed	25. Was case referred to medical				_		<u>d</u> ?	Were autop prior to con death? 1 ☐ Yes	nsy findings available inpletion of cause of
	this cer al direct	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	_ <u> </u>		er: 4 □ Nursin		heck only one) 5 ☑ Residend	ce 6 □Ott	ner_(Specify)
Division of Vital necords, F.O. Box 68/60,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: T	27. Manner of Death 1	28b. Time of Injury pme, farm, stre		y at √? Yes 2 □ No	28f.	Describe how Location (Stree City or Town, S	et and Numl		Route Number,
ho Hoenit	in 24 hours	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot 2 Medical Examiner: On the basis of examiner and manner stated.	wledge, death tion and/or inv	occurred at the tirestigation, in my o	ne, date and pl pinion, death o	lace, and ccurred a	due to the cau at the time, date	se(s) and me and place,	anner as st and due to	ated. the cause(s)
	5	2	29b. Signature and title of certifier						. Date signe		
			30. Name and address of person who completed cause of death (Iten Loveen J. Puthumana 3110 Gracef	ield Ro	rint) ad Silve	r Sprin	ng MI	20904			
	Stat Registra	е	JAN 04 2010 Series J.								

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Registrar

State

31. Date filed (Month, Day, Year)

JAN 05

State Registrar

31. Date filed (Month, Day, Year) 3

JAN 04 2010

Mas

30. Name and address of pen-rwh ampleted cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

2001

12.31.09

PRWY ANNAPOLIS, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20 FLORENCE FELICE AUBERTIN 2009 7 30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 - M 2 - F Days June 22, Year) 928 Hours Connecticut Director 040-22-4973 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21704 5948 Quinn Orchard Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Heafth and Mental Hygiene. iem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Fischetti Pasquale Petecchio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5948 Quinn Orchard Road, Frederick, MD 21704 William Aubertin / Husband If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery 20c. Location - City or Town, State Page 1 ō Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Important: It any injury or 12/28/09 Waterbury, CT 4 Donation 5 Other (Specify) 21. Signature of June al Septice Lice RÜBERFndEddredaffeey & SON FUNERAL HOMES, P.A. Sefert 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1, En er the disease, or Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No 5 Other (specify) Month Year Pregnant at time of death Day signed by the a d be detached for a \square Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No isease 2 No this certificate RV 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After 1 Natural ithin 24 hours after death.

the Funeral Director: After ompleted filled in by the fun 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Day, Year

P.O.

Records,

Division of Vital

s Signature

32. Registra

		State of Maryland / Don	ortment of Health and Mantal H	valore :
		101	artment of Health and Mental H <i>rtificate of Death</i>	Reg. No. 2009 43412
		Decedent's Name (First, Middle, Last)	2. Date of I	Death 3. Time of Death
Physic /Medi		Ruth Preston Brooks	12 Month	28 2009 11:23p m
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Future Care-Canton Harbor	Baltimore	N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 M 20 F 7. Age (In yrs. last birthday) 1 Yrs.	If Under 1 Year If Under 24 Hrs. 8, Date of B Months Days Hours Min. 3 2	9. Birthplace (State or Foreign Country) NA 9. Birthplace (State or Foreign Country) VA
		Usual Residence of Decedent	3 2	S IS VA
ırylan show	_	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits
he Ma 28a-f s	Director	iib build		1 □ Yes 2 No
with t	ä	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country? USA
hrs 23	Funeral	112 Calvin Hill Ct. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21222 Was Decedent of Hispanic Origin? (Specify Yes or I	
after o		1 Never Married 2 Married 1 Yes 2 KN No	Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes ※□No Specify:	
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural" or Items 23a or 28a-f show matic event, the Medical Eventines must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Black
15- n 72 h "nati	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
withii jiene.	mo	Elementary/Secondary (0-12) College (1-40r 5+)	rse	Bayview Hospital
e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	lle, Maiden Surname)
aryian should be and Mental s marked o	10	Robert Preston	Janice	Phornton
8 8 8 8 B			ng Address (Street and Number or Rural Route Nun 12 Calvin Hill Ct. I	
		20a. Method of Disposition 20b. Place of Dispo		20c. Location - City or Town, State
S I I I		1 Burial 2 X Cremation 3 Removal from State	matory or other place) unt Crem. 1/18/2010	· · · · · · · · · · · · · · · · · · ·
Baltim permit. Pag Departmen Important; any Injury once.		4 Donation 5 Otter (Specify)		
balt permit. Departi Import any Inji		121	101 E. North Avenue	FUNERAL HOME-EAST Baltimore, MD 21202
		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		
Physician			ENTLA	Onset and Death
/Medical Examiner		Due to (or as a consequence of):		7
Lxammer	<u>_</u>	Sequentially list conditions, b. — A S C	VD	
uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
exection and ital-tra	Exa	that initiated events resulting in death) Last c Due to (or as a consequence of):		
ate be ex ysician and be burial.	ical	d		
c bb e as th	Physician/Medi	IF FEMALE:		
BOX sath cer attendir for use	ian/	23b. Was decedent pregnant in the past 12 months?	⊒ Ectopic pregnancy	23d. Date of delivery Month Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)	
that the property of		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death?
COTOS w requires been sign should be	ed by		1	Yes 2 No 3 Probably 4 Nonknown
eco law rei as bee 2 shoi	Completed		24a. Wa	
The I	E O		au pe 1 □Yes	opsy prior to completion of cause of death? 2 400 1 Yes 2400
VITAL Ician: T certifical ector, pa	Be (25. Was case referred to medical examiner?	26. Place of Death (Check onl)	
O - O - O - O - O - O - O - O - O -	ို	1		sidence 6 Other (Specify)
Phys this			Work?	e how injury occurred
ding Phys h. After this funeral di	tion:	a la stating		
Attending Physical Color of Attending Physical Color C	fication:	2 Accident investigation 3 Suicide 6 Solution be 28e, Place of Injury - At home, farm, str.		(Street and Number or Rural Route Number,
UIVISION OI al or Attending Phys s after death. Il Director: After this d in by the funeral di	Sertification:	2 Accident investigation	eet, factory, office 28f. Location	(Street and Number or Rural Route Number, own, State)
OINISION OI Iospital or Attending Phys I hours after death. uneral Director. After this ally filled in by the funeral di	cal Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, str. building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deati	eet, factory, office 28f. Location City or T	own, State) ne cause(s) and manner as stated.
the Hospital or Attending Physinin 24 hours after death. The Funeral Director: After this mpletely filled in by the funeral directorial materials.	edical	2 Accident 3 Sulcide 4 Homicide 28e. Place of Injury - At home, farm, str. building, etc. (Specify) 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deatt and manner stated.	eet, factory, office 28f. Location City or T h occurred at the time, date and place, and due to the total vestigation, in my opinion, death occurred at the time.	own, State) ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
ding th.: trh: trhe	edical	2 Accident 3 Sulcide 4 Homicide 28e. Place of Injury - At home, farm, str. building, etc. (Specify) 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deatt and manner stated.	eet, factory, office 28f. Location City or T h occurred at the time, date and place, and due to the total vestigation, in my opinion, death occurred at the time.	own, State) ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directory.	edical	2 Accident 3 Sulcide 4 Homicide 28e. Place of Injury - At home, farm, str. building, etc. (Specify) 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deatt and manner stated.	eet, factory, office 28f. Location City or T h occurred at the time, date and place, and due to the total vestigation, in my opinion, death occurred at the time.	own, State) ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical	2 Accident 3 Sulcide 4 Homicide 28e. Place of Injury - At home, farm, str. building, etc. (Specify) 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deatt and manner stated.	eet, factory, office 28f. Location City or T h occurred at the time, date and place, and due to the total vestigation, in my opinion, death occurred at the time.	own, State) ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral disperse.	edical	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, str building, etc. (Specify) 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner stated.	eet, factory, office 28f. Location City or T h occurred at the time, date and place, and due to the total vestigation, in my opinion, death occurred at the time.	own, State) ne cause(s) and manner as stated. e, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

		1 - State of Registrar	Marylan			nt of H e of D		ınd M	ental Hygi	ene g. No.20	09	43413
		Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death
Physici Medi		William F. Becker						_	Month Decembe	r 29,	2009	12:13 p ^M
Exami		4a. Facility Name (if not institution, give street and numb	er)		4b. City	Town, or	Location of	Death		4c. County	of Death	
		Holy Cross Hospital				Sil	ver S	prin	ıg	1	Montg	omery
Funera		5. Social Security Number 6. Sex	. Age (In yrs. la	ast birthday)	If Unde		If Under 2	A Airo	8. Date of Birth	Voque)	9. Birth	place (State or Foreign
Director		579-20-7895 1XD M 2 D F		89 ^{Yrs.}	Months	Days	Hours	Min.	Aug 23,	1920	Wash	ington, DC
T MO	٦.	Usual Residence of Decedent 10a. State 10b. County	1.0.00									
yland f sh	[恴	10a. State 10b. County Maryland Montgomery	10c. City	y, Town or Loc Silve:		rina					1	0d. Inside City Limits
Mar 28a	ire			DIIVE.								1 🗌 Yes 2 🎦 No
th the	a C	10e. Street and Number			10f. Zi	Code			10	g. Citizen of	What Cour	ntry?
th wit ms 2;	Funeral Director	10706 Bucknell Drive			Ь			902		USA		
dea'		11. Marital Status 12. Was Deced Armed Ford	es?	5. 13. V	Vas Dece	dent of His cify Cubar	spanic Origi , Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		e - Americ	
after after xam	a p	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Ma	10/11	20 1	☐ Yes	2 X No	Specify:				Whit	
ours atture	Completed	3 Wildowed 4 Divorced Year or Date 15. Decedent's Education	es. IJII (16a. Deced	ont's Heu	al Occupa	tion		- 1	A 16 1 18		
72 h	를	(Specify only highest grade completed)		(Give k	and of wo	rk done di	uring most o	of workin	g	6b. Kind of B	usiness in	dustry
Z12 /ithin iene. iene.	3	Elementary/Seconday (0-12) College (1-2	or 5+)		torn	,				Law		
Hyg Hyg othe	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, Ma	aiden Surnam	e)	
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	₽	Francis J. Becker					Hort	ense	Edward	S		
ary and N s ma umat	1	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Addres	S (Street a	nd Number	or Rural	Route Number, C	City or Town, S	State, Zip C	Code)
Matha 27 is rrtra		Mary M. Becker/Wife			_				Silver			· ·
Te, Tang The item othe	1	20a. Method of Disposition		lace of Dispos	sition (Na	ne of		_ D	ate 2	Oc. Location	- City or To	own, State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	state St	emetery, crem • John	atory or c	other place emete	ry		1. 2, ²	Silver	Spri	ng, Maryland
Baltimo per mit. Page Der artment of Important II any injury or once.		21. Signature of Funeral Service Licensee		_22.	. Name ar	nd Address	s of Facility					5. Inlytona
Ber E		I John Kyle C May	-	5	ancı: 00 Uı	s J. niver	Colli	ns E Blvd	Tuneral	Home I ilver	nc. Sprin	g,MD 20901
		23a. Part 1. Enter the disease, or complications that ca	used the death	n. Do not ente	r the mod	e of dying	, such as ca	ardiac or	respiratory arres	t,	Ī	Approximate
Physician/		shock, or heart failure. List only one cause on each	Myocar	dial T	nfor	ation						Onset and Death 30 mins.
Medical		diodec of condition	r as a consequ		illar	CLOII					- 27	30 mins.
Examiner	1	Severe	Coron	,	tery	Dise	ase					30 years
	ner	Sequentially list conditions, b. — Due to (o	r as a consequ									
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.										
exec an an rial-tr	Ě	resulting in death) Last Due to (o	r as a consequ	ence of):								
760 cate be executed physician and the burial-transit	edical	d										
d / d	Mec	IF FEMALE:										
endir	an/I	23b. Was decedent pregnant 23c. If yes, outcome	ome of pregnar irth 2 🗌 Feta	ncy Ideath 3	Ectopic	pregnancy	,			23d. Da	te of delive	ery
BOX 68 death certifiche attending led for use a	sici	1 Yes 2 No 4 Pregna	ant at time of d		Other (s					Mo	nth	Day Year
that the	Physician/M	9 🗆 OTIKIOWII							1			
s that	5	Part II. Other significant conditions contributing to dea Renal Failure	ath but not resi	ulting in the ur	nderlying	cause give	en in Part I.		11			ne cause of death?
VITAI KECOTAS, ysician: The law requires is certificate has been sig	Completed								1 Tes	2 XX No	3 🗌 Prob	oably 4 🗆 Unknown
aw re	ble								24a. Was an autopsy		Were autor	osy findings available mpletion of cause of
The Is	μος								perform	ed?	death?	
ian: and refifice	Be	25. Was case referred to medical examiner?				26. Pla	ce of Death	(Check	-			
VIT nysic nysic nis ce direc	10	I double I Hospital:	patient 2 🕱	ER/Outpatient	3 🗆 D	Other	" 4 □ Nurs	sing Hon	ne 5 🗆 Resider	ice 6 🗆 Oth	er (Specify)
OT Pg Pt ter th neral		27. Manner of Death 28a. Date of 1 X Natural 5 ☐ Pending (Month	injury , <i>Day, Year)</i>	28b. Time of injury	2	8c. Injury work?	at	2	8d. Describe how	injury occurr	ed	
DIVISION tal or Attendir rs after death. al Director: Af	fica	2 Accident Investigation	. , ,		М		′es 2 □ N	No				
VISI prAtt ter d irect	Certificate:	4 \ Hamicide determined 28e. Place o	f Injury - At hou g, etc. (Specify)		et, factor	, office		2	8f. Location (Stre		er or Rural	Route Number,
ral D												
Hosp 24 hor Fune ted fi	Medical	29a. Certifier 1 Certifying Physician: To the beautifier (Check 2 Medical Examiner: On the basis	of examination	and/or investi	gation, in	my opinior	, death occ	urred at t	he time, date and	place, and du	e to the cal	use(s) and manner stated.
DIVISION Of VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ž	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifies	the best of my	knowledge, d	eath occu	rred at the	time, date a	and place	, and due to the c	ause(s) and ma	anner as sta	ated.
P. 2 6 8			area	AMI	790	100150	1 1 M		29	d. Date signed	viontn, L	oay, rear)
V					0	171	TU		/	2171	1000	7
		30. Name and address of person who completed cause Alan I. Kermaier, MD				Road	. #20	00. 9	Silver S	prina.	MD 2	0910
Sta	to		jistrar's Signat				, ,, ,,	-, .		r		
રાક Registr		JAN 04 2010 A.	A A	Maria	Kal.							

09-10113 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Dwight Biggar State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Dwight Biggar Medical Examiner December 26, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert Memorial Hospital Prince Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours Director 464-19-9179 48 02/11/1961 1X M 2 F Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 23a or 28a-f show notified at once, Lusby MD Calvert permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. irector 10e. Street and Number 10f. Zip Code 12468 Ridge Road 20657 United States ۵ Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 2 X No 4 Divorced 3 Widowed If Yes, Give Year 1 Yes 2X No specify: Þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical 12 4 Statistician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Blanch Marie Campbell Hubert Earl Biggar Be 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12468 Ridge Road, Lusby, Maryland 20657 Judith Ann Biggar (Wife) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/3/2010 Sand Hill Cemetery 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 0. Box 600, Lusby, Maryland 20657 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Complications of Obesity Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and sician/Medical **AMENDED** UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ā</u> Hypertensive Atherosclerotic Cardiovascular Disease; Diabetes mellitus of Vital Records, has 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death 1 🗸 Natural 1 Yes 2 No Pending 2 Accident Investigation

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 🗸 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No Other Nursing Home 5 Residence 6 Other 28d Describe how injury occurred within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Division 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) 29b Signature and title of certifier O.C.M.E. December 28, 2009 30. Name and address of person who completed cause of death (Item 23a) daw 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month Day Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL OCME 2006 OCME

3. Time of Death

1530 hrs

Texas

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

Country)

14. Race - American Indian, Black,

Specify: White

16b. Kind of Business/Industry

Census Bureau

20c. Location - City or Town, State

Center, Texas

23d. Date of deliver

Day

Month

U. S. Government

4c. County of Death

10g. Citizen of What Country?

Calvert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month <u>11:0</u>8 a ^M Marjorie C. Brooks December 22, 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Calvert 3920 Dares Beach Road Prince Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F 95 MD 213-38-1856 April 15, 1914 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo MD Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3920 Dares Beach Road 20678 13. Was Decedent of Hispanic Origin? (Specify Ye's or No-lf Ye's, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2. No 1 ☐Yes 2 X No Specify. Specify: 3 N Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Harrod Ethel D. Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Brooks - granddaughter 3960 Dares Beach Road, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December 30, 2009 | Huntingtown, MD Plum Point UMC Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mont Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death

Physician /Medical Examiner

Examiner or Attending Physician: The law requires that the death certificate be executed and attending physician

the

the

Physician

/Medical

Director

Be Completed by Funeral

2

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Expandmen must be redified at

or other traumatic event,

Important: If item 2 any injury or other

death with the Maryland

be filed within 72 hours after

Pages 1 and 2 should

Baltimore,

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ ted

9 Unknowh		·	
art II. Other significant cond	itions contributing to death	but not resulting in the under	erlying cause given in Part I.
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erlying cause given in Part I.	23e. Did tobacco us	se contribute to the cau	use of death?
- girear	1 □ Yes 2	No 3 □ Probably	4 Unknow
wey Hocoene	24a. Was an autopsy performed? 1 □ Yes 2 No	24b. Were autopsy fi prior to complet death? 1 Yes 2	ion of cause of

Comple	- D'I	and E	- Bena	Lin	2477	scoe.	24a. Was an autopsy performed?	24b. Were autopsy findings availal prior to completion of cause of death? 1 □ Yes 2 □ No
Ď	25. Was case referre	ed to medical			26.	Place of Dea	ith (Check only one)	
0	examiner?	No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4	☐ Nursing H	lome 5 Residence 6	G ☐ Other (Specify)
allon:	27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2	28d. Describe how injury	r occurred
Certific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		home, farm, street, factorify)	ory, office		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
alcai	29a. Certifier (Check only one)	Certifying Ph ☑ Medical Exam	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death occurr nation and/or investigati	ed at the time, d	ate and place n, death occu	e, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)

Jen 2

after deat Director:

within 24 hours a

To the Funeral D

State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lahesh Shah

Prince Frederick, MD

32. Registra/s Signature

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27 Day 200 Par Dec. Dorothy June Bowen 2:49 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 125 German Chapel Road Prince Frederick Calvert 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5 / 1 1 / 1 9 2 8 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Hours Min. 81 Yrs. Director 216-22-0752 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince Frederick 1 X Yes 2 No Calvert MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20678 USA 125 German Chapel Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Callie Lambert Labren Cummings Ashby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Bowen, Sr./Spouse 125 German Chapel Rd. Pr. Frederick, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 12/29/09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 22. Name and Address of Facility Raymond-Wood F.H., P.A.21. Signature of Funeral Service Licensee 031 Dunkirk, PO Box 430, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wodrovascular of disease or condition Medical resulting in death) Due to (or as d consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a d be detached f 9 Unknow P.O. uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? certificate 2 No Yes 2 1 Tyes Division of Vital 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my policies, death occurred. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0027189 128 am noma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 10 Huntingtown, Md. 20639 Isl. Rd. ZAHIR YOUSAF. 2417 SOLOMONS 31. Date filed (Month, Day, Year) 32. Registrants Signature State A. parlet Registrar

			State of Maryland / Dep 1 - State Registrar Ce	artment of Health and N <i>rtificate of Death</i>	lental Hygier Reg. t	0000 10117
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	Physici: /Medic		Robert Charles Baczynski		12 25	2009 11:10AM
3	Examin	er	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederic		4c. County of Death Calvert
34.	Funeral			If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
L	Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 184–28–8229 X M 2 F 72 Yrs.	Months Days Hours Min.	(Month, Day, Yea 08,18,193	PA PA
	and w		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl -f sho fied a	tor	MD Calvert Dunkirk			1 ☐Yes 2 ☐ No
	th the or 28a e notii	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath will	ral	11252 Ward Road	20754		USA
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	urs aft al', or xami	by	1 □ Never Married 2 Married 3 Married 3 □ Widowed 4 □ Divorced X If Yes, Give Year or Dates: -1959	1 ☐ Yes 2 ☐ No Specify:		Specify: white
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9	filed v Hygid Sther i	ပ္ပ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
<u></u>	Jid be Jental rked c	To Be	(unknown)	Mari	e Czepzyns	:ki
Maryland	2 shou and M is ma auma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, Cit	y or Town, State, Zip Code)
≥ ຜົ	1 and 4ealth 9m 27 ther tr		Suzanne Baczynski/wife 1125. 20a. Method of Disposition 20b. Place of Disp	2 Ward Road, Dunki		0754 Location - City or Town, State
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (<i>Specify</i>) 21. Sign force of 1 feral Serves as	natory 12/ 22. Name and Address of Facility	31/2009 C	Clinton, MD
ŭ	Der Imp		Jeffrey S. Nigro Mon GC	Lee 3125 Southern MD.	Blvd. Owi	Iome, Calvert, P.A. Ings. MD 20736
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Records,	uires t signe id be c	d by	A A C. S. S. S. S. S. S. S. S. S. S. S. S. S.	andonying daddo givon in ratti.		2 No 3 Probably 4 Unknown
S	w require s been sig should b	Completed			24a. Was an	24b. Were autopsy findings available
Re	The lav	ошо			autopsy performed 1□ Yes 2 2	prior to completion of cause of death?
Viital	ding Physician: The Interpretation of the In	BeC	25. Was case referred to medical examiner?	26. Place of Dear	th (Check only one)	72.103
<u>7</u>	Physic this ce	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatie			6 □Other (Specify)
O	ding Ph h. After thi funeral	tion:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
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	tal or rs afte al Dir	Certification:	3,(City or Town, St	
	Hospi 4 hour Funer tely fill		29a. Certifier (Check only (th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
\	⊢ <i>s</i> ⊢ ō		Fulia L Surate no	D0058960		ecember 26 2009
. ^.) a		30. Name and address of nerson who completed cause of death (Item 23a) (Type	Print)		
火	W 5		JULIA L. SURRATT MD 100 HOS	PITAL RD, PRINC	ETREDE	RICK MD
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar Signature	1		

DHMH 17 Rev 1/2001

		1 - State Registrar		-	Certificate of L		F	Reg. No	009	43418		
Physici		1. Decedent's Name (First, Middle, La Harold Christie	·			I	2. Date of Dea Month December	Day	2009	3. Time of Death 2:10 A M		
/Medi Examir		4a. Facilify Name (If not institution, gi 6706 Farcroft Ter	ve street and number)		4b. City, Town, or	Location of Death		4c. Co	ounty of Death			
Funeral Director		Social Security Number 6.	Sex 7. Age (In yrs. last birt	Layton thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Aug. 1.	h y, Year)	ntgomer 9. Birthp Cour Mic	y blace (State or Foreign higan		
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permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: Wh			
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and 2 shou ealth and M n 27 is mar er traumat		19a. Informant's Name/Relationship Susan E. Braine		6	Mailing Address (Street a	Terrace	, Laytor	nsvil]	le, Md.	20882		
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Depar Impor any Ir		21. Signature of Funeral Service Lice		5470	Muriel H. P. O. Bo	s of Facility Barber x 5038, I	Funeral Laytons	Home	, Md. 2	0882		
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The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			230	d. Date of delive	ery Day Year		
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director,		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation			ime of 28c. Injury Work	at ? ∕es 2 □ No	28d. Describe h	now injury o	occurred			
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154		30. Name and address of person who Robert Fields,	M.D. 181	09 Pri	nce Philip D	r., #200	, Olney	, Md.	20832			
Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	s Signature	p. parks							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 25. 9:10 P M Dec. Helen Bea1 2009 /Medical H. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10450 Lottsford Rd Prince Georges Mitchelville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Au Month | Pay 1 940 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 99 Months 190-03-7389 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show adical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Mitcheville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Rd 20721 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No þ Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant Fed Govt permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygit Important; If item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Henri Hoeltzel Maggalena Sturm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Wright/Executor 1901 18th St, N.W. Washington DC 20009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematory Falls Church, VA 01/04/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. Zehrlen 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): aftending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ XNo Month Day Year 5 ☐ Other (specify) the 9 🗆 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Aortic Stenosis 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 12/31/2009 29b. Signature and title of certifier 29c. License number 2 D25079 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Yablonowitz MD 8116 Good Luck Rd. #300 Lanham, MD 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature parked Registrar

			State of Maryland / Department of Health and 1 - State Registrar Certificate of Death	Mental Hygier	2000 126211
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
и	Physici		Robert Beckelheimer Sr.	December	8 2009 9:45 P M
No. of Street, or other Persons	/Medio		4a. Facility Name (If not institution, give street and number) (HOME) 4b. City, Town, or Location of Deat		4c. County of Death
			128 W. Ring FACTORY Rd # 1322 BELAIR		HARFORD
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		9. Birthplace (State or Foreign
	Director		247-22-1145 1 MM 2 F 86 Yrs. Months Days Hours Min	May 12, 1	923 ERWIN TENNESSE
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	f sho	ō			1 □Yes 2 ☑ No
	28a-	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	with		128 W. Circi Factory Rd # 1322 21014		USA
	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adjest Exeminar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - American Indian,
9	after or ite	F	Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No Specify:	rto Hican, etc.)	Black, White, etc.
5-0036	ral",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: (143 - 1146)		Specify: White
5-(Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking	. Kind of Business/Industry
2121	filed within Hygiene. ther than '	쿹	Elementary/Secondary (0-12) College (1-4or 5+) 12 CHEM (51		wearch, Madical
	e filed value Hygie other i			me (First, Middle, Maid	HI GOVERN MENT
Maryland		Be	A 22 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	_	PEARSON
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ē,	1 all		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	. Location - City or Town, State
90	⊕ - - -		Tablina 2 dolemation of removaring state	2/8/09 00	blime 4 MD - 21201
altimore,	First art		21 Signature of Funeral Service Licenseed 22 Name and Address of Facility	1	
m	Depa Depa Impo any Ir		Rohald S. Hade Director State Anatomy B Baltimore, MD	30ard 655 W 21201	. Baltimore Street
		•	23a. Flart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory arrest,	Approximate Interval Between
	Physician			d Coronal	I Unser and Death
	/Medical		resulting in death) Due to (or as a consequence of):	(CDI STILL	J. J. J. J. J. J. J. J. J. J. J. J. J. J
	Examiner	,	Sequentially list conditions b. Leval insufficiency, Hyperlypide	me	25 year
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	icate be executed physician and the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Cerctral vascubir disease. Pe Due to (or as a consequence of):	righered us	isculator 25 gran
8760,	be e		_ == (it failure	
387		edical	, 8	U TOUR	
Box (that the death certif ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
ğ	death e atte d for i	icial	in the past 12 months? 1		Month Day Year
P.0		hys	9 Unknown		
S, F	res tha signed be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ğ	w requires that the been signed by th should be detache			1 ☐ Yes	2 MrNo 3 Probably 4 Unknown
9	~ 0 %	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ě	The ate h	ĕ		performed	? death?
Vital Record	ician: The certificate ector, pag	Be C		eath (Check only one)	
of V	Physician: this certific al director,	70 E	I Hospital'	Home 5 Residence	e 6 □ Other (Specify)
ū	ding Physician: h. After this certifica funeral director, p	on:	27. Manner of Death 1 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28c. Injury at Work?	28d. Describe how in	njury occurred
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Division	al or Attending F s after death. I Director: After d in by the funers	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Si	t and Number or Rural Route Number, tate)
ш	pital ours a leral filled		29a. Certifier 1X Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place.	ce and due to the caus	se(s) and manner as stated
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date	and place, and due to the cause(s)
	To th withir To th сощр	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
			1. Dotatontolo Ma, D22409		01/06/10
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph D Motor 0 St. M.R. 2205 York RD. 3uife/81 31. Date filed (Manth, Day, Year) 32. Registrar's Signature	Timonium	Maryland 21893
	Sta	te	31. Date filed (Month, Day, Year)		, 0
	Registr	ar	ALI - COID /		

			1 - For State Registrar	State o	f Marylar		artmer <i>rtificat</i>		ealth and Death	Mental	Hygiei	21113	43421
			1. Decedent's Name (First, Middle,	Last)						2. Date	of Death		3. Time of Death
	Physici /Medio		Rurton	I. Bellf	ield					Dec.	2ϵ	2009 Year	2:45 P M
r	Examir		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of Dea			4c. County of Deat	
1			Gladys Spellm	nan Nursi	ng Home	е	I	Hyatt	sville			Prince G	eorge's
	Funeral		Social Security Number		7. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under 24 Hr		of Birth h, Day, Ye		hplace (State or Foreign Juntry) District
	Director		579-44-1648	1 M 2 □ F		78 Yrs.	WORTERS	Days	Tiodis		22,	1931 of	Columbia
	pu *		Usual Residence of Decedent 10a, State 10b, County		10c C	ity, Town or Lo	antina						2.22
	aryla	5			100.0	ity, TOWN OF LC							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ne M	Director	DC					shin	gton		ү		
	Mith 1		10e. Street and Number				10f. Zip				10g.	Citizen of What Co	untry?
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	hours after deeth with the Maryland tural; or Items 23a or 28a-f ahow al Examinar must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Armed Fo		J.S. 13.	was Deced If Yes, spe	dent of Hi cify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes of rto Rican, etc	or No- :.)	14. Race - Ame Black, White	
36	irs af	by F	3 X Widowed 4 ☐ Divorced	If Yes, Giv	e		1 🗆 Yes	2 🔼 No	Specify:			Specify: Afr	cican
ŏ	2 hou	P	15. Decedent's	Education		16a. Dece	dent's Usua	al Occupa	ition		16b	Kind of Business/	rican
215	within 72 ene. than "nat	Completed	(Specify only highest (Specify only highest (Specify only highest (Specify only 10-12)	grade completed) College (1	Aor Eu	(Give	kind of wo DO NOT u	rk done d se retired	luring most of wo)	orking			,
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g	be filed within 72 hours after deeth with the Marylan Ital Hyglene. Id other than "natural", or Items 23a or 28a-f ahow of other than "haldsal Examinar must be notified as	Be	17. Father's Name (First, Middle, La	st)					18. Mother's Na	me (First, M	iddle, Maid	en Sumame)	
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Maryland 21215-0036	2 should be fi and Mental H is marked ot raumatic aver	10	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Number or F	lural Route N	umber, Cît	y or Town, State, Z	Zip Code)
	D = C =		Malik A. Polla	rd/ Gran	dson	1291	4 Win	dbro	ok Driv	e Cli	nton,	Md. 20	735
ore	of He		20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3	□ Romoval from !		Place of Dispo cemetery, crer	sition (Nar	ne of other place	Jan	Date uary	20c.	Location - City or	Town, State
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Baltimore,	permit. Pages 1 an Depertment of Heal Important: if Itam 2 any injury or other		21. Signature of Funeral Service Lin	ensection .	HAD	1/1 22	2. Name an	nd Addres	s of Facility S	tewart	Fune	ral Home	, Inc.
_	207 2 2	b 48	MOIONO.	1000	Ajus	11 4	001 B	enni	ng Rd.	NE Wa	shing	ton, DC	20019
	Physician and /Medical Examiner ransit libe parial-transit	Examiner	23a. Part. Enter the disease, or constant shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneur Due to (_	quence of):							Interval Between Onset and Death
P.O. Box 68760,	the death certific y the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∐Pregn 9∐Unkno	nth 2 ☐ Feta ant at time of c wwn	al death 3 [Ectopic pr	ecity)				23d. Date of deli Month	Day Year
	8 50	P	Part II. Other significant conditions	s continbuting to de	ath but not res	sulting in the ui	nderlying c	ause give	n in Part I.			_	the cause of death?
5	w require been si should b	etec									1 🗌 Yes	2 No 3 Pr	obably 4 🔯 Unknown
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₹	Physicien: this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of De				
ō	Phys this ral di	5	1 Yes 2X No 27. Manner of Death	1 □ Ir	npatient 2	ER/Outpatien 28b. Time of		/A	4 (X Nursing			6 ☐Other (Spec	cify)
5	ding h. After fune	盲	1 ☑ Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury	м	8c. Injury Work	at ? ′es 2 ∐ No	28d. Desc	ride now in	jury occurred	
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_	To the Mospitel or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying I	Physician: To the	best of my kno	owledge, death	occurred	at the tim	e, date and plac	e, and due to	the cause	(s) and manner as	stated
	e Ho Fu e Fu	edical	(Check only 2 Medical Ex	aminer: On the ba and mann	sis of examina	ition and/or inv	estigation,	, іп ту ор	inion, death occ	urred at the t	ime, date a	ind place, and due	to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier				290	. License	number		29d. [Date signed (Month	n, Day, Year)
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0	5		30. Name and address of person wh	o completed cause	of death (Iter	n 23a) (Type.	Print)				1000	. 50, 200	
	_		Lester Miles M.	D 1160 Va	rnum S	treet 1	NE W	ashi:	ngton, I	OC 200	017		
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1) 5 2010	Beneva)	egistraris Signa	have	r						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ai yitai i	•		te of L		and with	orital Try	Reg. N	<u>.20</u>	09	431	+22
	Physicia	n/	Decedent's Name (First, Middle, Las NAOMI BARNES	t)							2. Date of De Month 12–31	ath		Year	3. Time of 2230	Death M
	Medic Examin	ical						y, Town, or	Location of	of Death	12 31		c. County	of Death	12230	
	B Varia									g			lontgo	omery		
	Funeral Director		244-08-0408	x	66 (In yrs. 16	ast birthday) Yrs.	Months		If Under Hours		8. Date of Bir 01-05-		3	9. Birthp Count	olace (State o try) NC	r Foreign
	and show	lor	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside Ci	
	Mary 28a-f otifie	Director	Maryland Prince G	eorge's	B1a	densbu	~	_							1X Yes	2 🗆 No
	with the s 23a or ust be n	Funeral D	10e. Street and Number 5999 Emerson Stre	et, #702	10f. Zip Code 20710			10			10g. 0	Citizen of What Country?				
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	ver in U.S No				ispanic Origin, Mexican Specify:		fy Yes or No- can, etc.)		Blac	e - Americ ck, White, e Blac	etc.	
215-0	iin 72 hou ie. han "natu • Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)		+)	life. Di	kind of w O NOT u	ork done o se retired)	during mos	t of working	7			usiness Inc		. +
2	d with dygier that the	Be C	12th 17. Father's Name (First, Middle, Last)			Die	etic:	ian A		or's Name	First, Middle,				ernmen	16
/lanc	d be file Mental H arked o	10	William Mitchell								hnson	iviaide	n Sumame	=) 		
, Man	d 2 shoule alth and h		19a. Informant's Name/Relationship (7) Wanda J. Barnes/n			19b. Mailir	ng Addre D Lal	ss (Street a	and Numbe	er or Rural i	Route Number, Mitc	er, City o	or Town, S 1vi1	State, Zip C	ode) ID 2072	21
Baltimore, Maryland 21215-0036	Page 1 an ment of He tant: If iten jury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specified)		0	Place of Dispo emetery, cren lar Hil	natory or	other place	ry C	DE 01-07-				City or To	wn, State aryland	i
Ball	permit Depart Impor any in	Į Į	21. Signature of Funeral Service Licens Mary Tedamo	m M0137	4	Ce	. Name : edar	and Addres Hill	ss of Facilit	ty 4111	PA Ave	e.,	Suit	land,	, MD 20	0746
	WW		shock, or heart failure. List only one cause on each line.									Approximat Interval Bet Onset and I	ween			
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3760	ate be ohysici the bu	Aedical		d												
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant									*	Y ear			
Records, P.O.	es that the signed by be detac	by	Pair II. Other significant conditions contributing to death but not resulting in the directlying cause given in Pair II.													
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Division of Vital	I or Atten after deat Director: d in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	M 1				-	28f. Location (Street and Number or Rural Route Number, City or Town, State)				oer,		
	e Hospita 124 hours e Funeral	Medical	29a. Certifier 1 X Certifying Phys (Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of ex	kaminatior	n and/or invest	tigation, i	n my opinio	on, death o	ccurred at the	ne time, date :	and plac	ce, and due	e to the cai	use(s) and ma	inner stated
	To th withir To th	2	29b. Signature and title of certifier	29c. License number 29d. Date signed (Mon 01-01-20)							d (Month, I	Day, Year)				
	S		30. Name and address of person who of Bergit Schoellma		eath (Item	23a) (Type, F : G1en	Print) Road	l, Si	1ver	Sprin	g, MD	209	10			-
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DHMH 17 Rev 7/2009

			State of Marylan 1 - State Registrar		artment of F rtificate of I			leg. No. 2009	3 43423	
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death	
w.,	/Medic	al	JOHNSON BALOGUN 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	DEC	4c. County of Dea	th	
*	<u> </u>		FUTURE CARE NURSING HOME		BALTIM If Under 1 Year	IORE If Under 24 Hrs.	To Date of Black	BALTIMO		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1449–53–5004 1 X 2 F 57	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day NOV 12	(, Year) C	thplace (State or Foreign ountry) ERIA	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
	e Mary la-f sh	ctor	MD PRINCE GEORGES LA	NHAM					1 XYes 2 No	
	with the	Director	10e. Street and Number		10f. Zip Code 2070	16	1	10g. Citizen of What C USA	ountry?	
	death	Funeral	7014 FORBES BLVD 11. Marital Status 12. Was Decedent Ever in U.	S. 13. \		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-			
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evaninar must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	- 1	1 □Yes, specify Cuba 1 □Yes 2 No		Hican, etc.)	Black, Whi	BLACK	
15-0	n 72 ho i "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of work	ing	16b. Kind of Business	/Industry	
212	d withi giene. er than	Somp	Elementary/Secondary (0-12) College (1-4or 5+) 4+			ISTRATIVE		PRIVATE		
and	be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) PATRICK BALOGUN				e (First, Middle, i NI	Maiden Surname)		
aryl	2 should be filed within and Mental Hygiene. is marked other than ' aumatic event, tre Mo	욘	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, State,		
	1 and 2 Health a em 27 is		SHIRLEY F. BALOGUN/DAUGHTER			BLVD LANH				
Baltimore,	permit. Pages 1 and Department of Heat Important: If item 2 any Injury or other ODCE.	,	#EI D	emetery, cren	esition (Name of matory or other plac COLN CEME	TERY 12/3		20c. Location - City of BRENTWOOD,	MARYLAND	
Bal	permit Depar Impor any In	(21. Signature of Emeral Service Licensee		2. Name and Addre 7474 LAND			NKINS FUNE ER,MARYLAN		
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the control		arrythe	mias			30 MINULES	
	Examiner		Athora	tic hear	nt dise	aie		4 years		
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated are that in the desired are the conditions of the c				20413			
0	ificate be executed g physician and as the burial-transit	Еха	resulting in death) Last Due to (or as a consequence)	uence of):					, , , ,	
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O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of Month 5 □ Other (specify) 9 □ Unknown						elivery Day Year	
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ord	w require s been siç should b	ted t	Chronic menol failure, A				1 🗆 Y	es 2 No 3 F	Probably 4 Unknown	
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Vita	slcian: The certificate I rector, page	Be C	25. Was case referred to medical examiner?		Oth	26. Place of Dea	th Check only or	ne)		
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sion	tending eath. or: Aft the fun	catio	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be	Injury	M 1 □	K? Yes 2□No				
DIVI	after d after d Direct d in by	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify the specific states of the specify that is a specific state of the specific states of the	me, farm, stroy)	eet, factory, office		28f. Location (S City or Tow	(Street and Number or Rural Route Number, own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2	wledge, deatl	h occurred at the tilvestigation, in my o	me, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) and manner date and place, and du	as stated. ue to the cause(s)	
_	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mor		
	/		De Kosn			04014		12-24-	2009	
	A		30. Name and address of person who completed cause of death (Item **DESAI MO DIG Maiden C**)			ottons ville	e mo	21418		
ı	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signa A. O 5 2010		4.1					

DHMH 17 Rev 1/2001

JOHNSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 Miriam L. Cole December 7:53 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery . Social Security Number 8. Date of Birth (Month, Day, Y March 21 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days Hours Min 1 M 2 X F Massachusetts 1936 Director 011-30-7161 73 March Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified 1 XYes 2 No MD North Bethesda Montgomery 10e, Street and Number 10g. Citizen of What Country? Funeral 10401 Strathmore Park Court #204 20852 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter Black, White, etc. þ 1 Never Married 2 K Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Shopper Lord & Taylor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Oscar Turran Bertha Berowitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod $^2_{
m P}$ 19a. Informant's Name/Relationship (Type, Print) 10401 Strathmore Park Court #204 NorthBethesda, MD Elliot H. Cole / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 12/28/2009 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility and Sagel Funeral Direction, INC een Melissa Greenhu 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Lymphoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or Impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ NTOIN | To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🕱 No 2 X No Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 😾 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signat 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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pleted cause of death (Item 23a) (Type, Print)

Year,

0

8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ^{Day} 28, 2009 December 12:27 PMM Robert A. Chesser Jr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7734 Gough Street Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 19, Year 962 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mary Tand 1 X M 2 □ F 47 217-88-6228 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shorth Medical Expr. ingr. must be notified at 1 X Yes 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 21224 7734 Gough Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. white þ 3 Widowed 4 Divorced Completed unk unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be th and Mental F Robert Albert Chesser Sr Mary Catherine Pavalkos 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 7734 Gough Street Baltimore, MD 21224 Tiffany Chesser/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 w 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER of Physician months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and physician a the burial-1 Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending p as IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No certificate 2 🗆 No 1 Yes 1 ☐Yes To the Hospital or Attending Physician: After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed William Wa

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

09-10161 Shanti Coates Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Shanti Coates		1- For State Registrar	aryland / Depa <i>Cer</i>	artment o rtificate o		l Mental Hy	_	eg. No. 2009	43426
Physicia Medical Exami		Decedent's Name (First, Middle,Last) Class and disconnections	Costos				2. Date of Dea Month	nth Day Year r 28, 2009	3. Time of Death 1045 hrs
		Shanti 4a. Facility Name (if not institution, give street	Coates and number)		4b. City, Town, or L	ocation of Death	Decembe	4c. County of Death	
		Prince George's Hospital Cente	•		Cheverly			Prince George	e's
Funeral Director		Social Security Number 6, Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs, Hours Min.	8. Date of Bir	rth(MM/DD/YYYY) 9. Bir Foreig	
Director		220-15-2993 1 M 2 Usual Residence of Decedent	X F 3	2 Yrs			oct.3	31,1977 °°	untry) DC
any		10a. State 10b. County	10c. City,	Town or Locat	ion				10d. Inside City Limits
Varyland 28a-f show any d at once.	ō	MD Prince Ge	orge Cap	ital 1	Heights				1 X Yes 2 No
Maryl.	rect	10e, Street and Number	•		10f. Zip Code	Ō	1	0g. Citizen of What Cour	ntry?
ith the 23a on notifie	a Di	1809 Clark Place	D 1 1 1 5 1 1 1	0 140 111	20743			USA	
eath w	uneral Director		as Decedent Ever in U. med Forces?		s Decedent of Hisp es, specify Cuban,			14. Race - Ameri White, etc.	can Indian, Black,
after d	by Fu	3 Widowed 4 Divorced If Yes, Cor Date		1	Yes 2X No	specify:		Specify: Bla	ıck
hours	edt	15. Decedent's Education (Specify only higher	est grade completed)		it's Usual Occupation			16b. Kind of Business/I	ndustry Commerce
36 hin 72 e than "		Elementary/Secondary (0-12) Co.	lege (1-4 or 5+)	Clei	ck			_	sus Governmen
215-0036 be filed within 7 ntal Hygiene ked other than	Completed	17. Father's Name (First, Middle, Last)		CTE		8 Mother's Name (First, Middle, M	L	Governmen
D 21215-00; should be filed with and Mental Hygiene 7 is marked other to natic event, the Men	Be	Calvin Patrick C				Shiela			
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f shotraumatic event, the Medical Examiner must be notified at once.	입	19a. Informant's Name/Relationship (Type, Pri Shiela Coates/Mot	•	2.0				nber, City or Town, State, Heights, MI	1.7
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition	20b. F	Place of Dispos	ition (Name of cem-		Date	20c. Location - City or	
Baltimore, permit. Pages ar Department of Her Important: If ite		1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other Specify:	Ovar ironi otate	rematory or oth		ional 1	/4/10	Suitland	I MD
altin	1	21. Signature of Funeral Service Licensee						Funeral	
		23a. Part I. Enter the disease, or complications	cc0278	38	331 Geor	gia AV	e.NW	Washingto	
Physician dittal		failure. List only one cause on each line.			ie mode or dying, s	uch as cardiac or i	respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
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	اءِ	Sequentially list conditions, b.							
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P sed	Examiner	events resulting in death) Last Due to (or as a consequence of):		•			
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed leath. To Alter this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	edical	d. UNPENDED AMEN	DED				 		
Box 68760, : death certificate be exthe attending physiciar	Mec	IF FEMALE: 23c.	f yes, outcome of pregn	nancy			_	23d. Date of delivery	
× 6876 h certificate tending phy use as the l	sician/M	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of		al death 3 ner (Specify)	Ectopic pregnand	су	Month D	ay Year
Box e death the atte	Physi		death Unknown	h-sarad					
P.O.		Part II. Other significant conditions contribu		sulting in the u	nderlying cause giv	ren in Part I.		bacco use contribute to t	
ords, Pw requires to be seen sign should be contact.	Completed by	Diabetes Mellitus; Morbid Obes	ty				24a. Was a		opsy findings available
COFC law re has be	ם		· · · · · · · · · · · · · · · · · · ·				autops	sy prior to co	ompletion of cause of
tal Rec		25. Was case referred to medical			26 Place o	f Death (Check on	1 Yes 2	2 No 1 Yes	s 2 No
Vita ysician his cer direct	o Be	examiner? 1 ✓ Yes 2 No	Inpatient 2	ER/Outpatient	- 10	ther Nursing		Residence 6 Other:	
ding Ph	-1	27. Manner of Death 28a	Date of Injury (Month, Day,Year)	28b. Time of Ir	· · I		8d. Describe h	now injury occurred	
Sior Attend death death sctor:	<u>ĕ</u>	2 Accident Investigation				s 2 No			
Division of Vital Records, pital or Attending Physician: The law requirence death. eral Director: After this certificate has been similed in by the funeral director, page 2 should be.	Certification;	Suicide Could not be	. Place of Injury - At hore ecify)	me, farm, stree	t, factory, office bui	Iding, etc. 2	8f. Location (S or Town, St	street and Number or Rur tate)	al Route Number, City
ospi hou y fill		4 Homicide 29a. Certifier 1 Certifying Physician: To t		e, death occurr	red at the time, date	and place, and d	ue to the cause	e(s) and manner as state	d.
To the Howithin 24 F	Medical	2 Medical Examiner: On the and ma							
الو	Σ	29b/Signature and title of certifier		-	29c. License			29d. Date signed (Mon	
		(courtell)	d annua of days (1)	220)	O.C.M	.C.		December 29, 20	U9
		Name and address of person who complete Laron Locke MD. Assistant Me	d cause of death (Item 2 edical Examiner		Street, Baltimo	ore, MD 2120	1		
Sta	te	B1. Date filed (Manth, Day, Year)	32 Registrar's Signatur	par	41				
Registr		DAIA 0.5 COIO	Ceneva B	JAMERI	-				4

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 2009 0k Ryan Choi

4b. City, Town, or Location of Death

4a. Facility Name (if not institution, give street and number)

3. Time of Death

Korea

10d. Inside City Limits

Asian

Interval Between Onset and Death

1 Yes 2 No

4c. County of Death

7:30pm

	Physicia Medi Examir	
	uneral irector	
Maryland	28a-f show otified at	

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no permit. Page 1 and 2 should be filed within 72 hours after death with the Baltimore, Maryland 21215-0036

> Physician/ Medical Examiner

ending physician and use as the burial-trar Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the sign I be Division of Vital Records, certificate has b lirector, page 2 sl

Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country)
 Value 0.5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
June 07, 1922 1 □ M 2 🗓 F Months Days 060-68-0859 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Catawba Manor Court 20871 Korea 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jung Dong Yul Kim Cha Nam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandon Park - Grandson Catawba Manor Court, Clarksburg, Maryland 20871 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify 01/04/2010 | Olney, Maryland Norbeck Memorial Pk. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or comilientions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or feart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Asystolic Arrest Due to (or as a consequence of) Huperkalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Acute Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Sepsis 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 K No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No 1 Marient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067386 December 30. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

John,

Sonia

M.D.

9901

Registrar's Signat

MUL

Medical Center Drive, Rockville, Maryland 20850

			Please	Type or Print in State of Maryla				-	_	3 43428	
			1 - State Amend#17PerVR Registra Amend#17. Per	PGC1-7-2010cm FHPGC1 <i>-</i> 6-201	ocr Ce	rtificate of	Death	F	Reg. No.	7 43420	
	Physici /Medic		Decedent's Name (First, Middle, Las Landa	t) Cunningham				2. Date of Dea Month Pecen	Day Year	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea		
	Funeral		Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	Oxon Hi		8. Date of Birt	h 9. Bír	orge's Co. thplace (State or Foreign	
	Director		567-78-0829 1 Usual Residence of Decedent	□ M 2 X F 53	Yrs.	Months Days	Tiours Will.	10/11/1		yland	
	show		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits	
	he Ma 28a-f s	ecto	MD Prince G	George's 0	xon Hil	1 10f. Zip Code			10g. Citizen of What C	1 XYes 2 No	
	3a or	Funeral Director	10e. Street and Number 115 Seneca Drive			20745			USA	ountry :	
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto				
36	rs afte	by Fi	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ∑xNo If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	Specify:	_{Specify:} African American			
5-0(72 hou natura Jical E	eted	15. Decedent's Ed	ucation de completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	ina	16b. Kind of Business		
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT use retire</i> ng Assist			Private		
	should be filed within 72 hours after death with the Maryland ind Mental Hygleine. It marked other than "natural", or Items 23a or 28a-f show umatic event, it we Welfall Evriciant: just be routified at	Be C	17. Father's Name (First, Middle, Last)	/25 12		0	18. Mother's Name		Maiden Surname)		
Maryland	ould b	2	Lonnie Curningham	•	405.44-77		Johnnie		ımber, City or Town, State, Zip Code)		
	nd 2 sh aith an 27 Is r r traur		19a. Informant's Name/Relationship (3 Johnnie Cunningha				ive, Oxon			Zip Code)	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importants if item 27 Is marked other than "natural", or items 23a or 28a f show any Injury or other traumatic event, it is Wedical Exercise from the condition any Injury or other traumatic event, it is Wedical Exercise from the condition at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	201	p. Place of Disoc		-	Date	20c. Location - City or	Town, State	
ţ	it. Pag irtment irtant: njury o		4 ☐ Donation 5 ☐ Other (Specify	<i>)</i> R		e Cremato 2. Name and Addre	ory 1/4/2		Riverdale,		
Ba	Depar Impor any Ir	9	21. Signature of Funeral Service Licen	see			0.1		ns Funeral over, MD 20		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the do				The second secon		Approximate Interval Between Onset and Death	
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Brain		nan				Chook and South	
Y	Examiner			Due to (or as a cons	sequence or).						
	ted isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as e cons	sequence of):						
Ć,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):						
68760,		dical		d							
Box 6	eath certificate attending physi for use as the I	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre			5		23d. Date of de	elivery	
-	Physician: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	Physician/Medic	in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	У		Month	Day Year	
, P.O.	res that the designed by the standard be detached	Phy	9 ☐ Unknown Part II. Other significant conditions or	ontributing to death but not	resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	Did tobacco use contribute to the cause of death?		
Records,	w requires s been sign should be	ed by						1 🗆 \	∕es 2 No 3 F	Probably 4 nknown	
Seco	e law re has be e 2 sho	Completed	24a. Was an autopsy prior to completion o								
Vital F	iclan; The certificate h rector, page		25. Was case referred to medical				26. Place of Deat	1 □ Yes		s 2 No	
f Vi	nysicia nis cert direct	lo Be	examined? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA Oth	or:		dence 6 ☐ Other (Sp	ecify)	
on of	ding Ph h. After th funeral	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	Wor	ryat rk? ÎYes 2 □No	28d. Describe I	now injury occurred		
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm, st		Tres 2 DNO	28f. Location (S	Street and Number or F	Rural Route Number,	
۵	ital or urs afte ral Dir lled in										
	e Hosp 124 hor e Fune eletely f	Medical		ysician: To the best of my niner: On the basis of exam and manner stated.							
_	To the vithir comp	Me	29b. Signature and title of certifier	117		29c. Licens	se number	_	29d. Date signed (Mor	nth, Day, Year)	
	^		Harmeler .	/g/soplen	<i>90</i>	HO!	0559	27 -	I AN wany	1,2010	
R	2		30. Name and address of person who a	completed cause of death (I	/ Hos	oital.	Drive,	Cheve	rh ma	ryland	
	Sta Registr	-	31. Date filed (Month, Day, Year)	efter 300 32. Registrar's Signature	gnature				1/		
	.1091311		- O C LUIU		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1305 EDWARD M. CANNON DEC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F Months Hours Mir 46 Director Usual Residence of Decedent items 23a or 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Funeral Director 10d. Inside City Limits Ston 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U5 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 PBurial 2 Cremation 3 Removal from State 9/2010 4 ☐ Donation 5 ☐ Other (Specify) Park 01 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani MYCLARDIAL INFARCTION 6 HOURS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner COKONARY ARTERY UNENDIN DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or). To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Year Day 2 No has been signed by the e 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page neral Director; After this certificate I filled in by the funeral director, page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 X Yes 2 □ No Be (26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number P21124 DEC 31 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD P. PERRIN II, MD 22 S. GREENE ST. BALTIMORE, MD 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43430 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1, 2009 Physician/ Lyle T. Cheatham 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5264 Chalk Point Road Anne Arundel West River 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M M 2 □ F (Month, Day, Year) 10/06/1920 **Director** 577-03-2232 89 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Anne Arundel West River 1 Yes 2xXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5264 Chalk Point Rd. 20778 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Treasurer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lyle Cheatham Kathleen Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Dellinger 2057 Ingleside Ct. Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place 1/5/2010 Davidsonville, MD Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. at Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. nterval Between Prostatic Carcinoma Onset and Death Immediate Cause (Final Physician/ 65 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 038563 29d. Date signed (Month, Day, Year) December 31, 2009

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

134 Oversielle Red, West River, My

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bierbaum

ayne 31. Date filed (Month, Day, Year)

JAN 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death System Month Day Physician 50 P M 10.00× /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arunde1 խ Hicks Avenue Annapolis Hours Min. June 16 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 936 1 □ M 2X F Months Days Louisiana 461-58-2822 73 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinations to be restified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Anne Arundel Annapolis 1X Yes 2 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Hicks 21401 USA Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? 1 □Yes 2 XNo Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: <u>გ</u> Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) 8yrs Educator Anne Arundel Co. Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lionel Phillip Pointer Sedonia Robertson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 96867 19a. Informant's Name/Relationship (Type. Print) <u> Crandel M. Chambers,MD(Son)</u> 5413 River Oak Way Phenix City, Alabama Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran 1 - 4 - 10Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Minimame Reposes of Facility ons Mortuary, P.A. 21. Signature of Funeral Service Licensee Harry MOO 482 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2.27 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 2 No 2 1 □ Yes 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 □No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. of Vital Records, Division ours after death.

neral Director; A To the Hospital within 24 hours a To the Funeral D

JT1 State Registrar

31. Date filed (Month, Day, Year) JAN 05

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registraris Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

		For State	State of Ma		artment of Health rtificate of Death	-	200	9 43432			
	_	Registrar 1. Decedent's Name (First, Middle, Last.))		Tillicate of Death	2, Date of De	neg. No.	3. Time of Death			
Physici		ANNASTASIA		CHRI	STOFEL	Month	Day Y	2000 M			
/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or Location	of Death	4c. County of				
<u> </u>		Sunrise Assisted			Annapo			Arundel			
Funeral Director		220 10 3200	7. Age	e (In yrs. last birthday, 85 Yrs.	If Under 1 Year If Unde Months Days Hours	Min. 8. Date of Bi	3, 1924	Birthplace (State or Foreign Country) New York			
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation			10d. Inside City Limits			
Maryl a-f sho	ctor	Maryland Anne Ar	undel		Annapoli	.S		1 □Yes 2 □No			
th with the 23a or 28	Funeral Director	10e. Street and Number 800 Bestgate Road	l		10f. Zip Code 21401		10g. Citizen of Wha	at Country? S.A.			
If the within 72 hours after death with the Maryland Hygiene. Hygiene with attural" or Items 23a or 28a-f show ent, the Madical Evolution is ust be rectified at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☑ N If Yes, Give		Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 □Yes 2♥No Specify	an, Puerto Rican, etc.)		American Indian, White, etc. White			
2 hour		15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occupation	at at warding	16b. Kind of Busin				
within 72 ho giene. r than "natu	Completed	(Specify only highest grad	e completed) College (1-4or 5-	life.	kind of work done during mo DO NOT use retired) Receptionist	•	County G	overnment			
filed Il Hygi other	Be Co	12 17. Father's Name (First, Middle, Last)			18. Moth	ner's Name (First, Middle					
Menta	To B	Nick Manis			Ha	rriet Dedic	os				
and 2 sho saith and 1 27 is ma er traum		19a. Informant's Name/Relationship (Ty William G. Christo			ng Address (Street and Numb 120th St., #1						
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I'm Monee.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	demoval from State		osition (Name of matory or other place) Crios Cemetery	Date 7 1/2/2010	20c. Location - Cit Annapoli	ty or Town, State s, Maryland			
permit. Departr Importa any Inju		21. Signature of uneral Service Licens	" Till		2. Name and Address of Faci						
-		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do not en	ter the mode of dying, such a	s cardiac or respiratory	arrest,	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition resulting in death) a. Court on Chronic Reprictory of Chronic Reprise Reprictory of Chronic Reprictory of Chronic Reprictory of Chronic Reprictory of Chr									
/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	(000		10	1. 6. 21.22			
	er	Sequentially lifet conditions, if any, leading to immediate	Due to (or as a	a consequence of):	C 05 11			y search			
cuted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s								
ficate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a	a consequence of):							
icate physi s the b	dical		1								
Attending Physician: The law requires that the death certific rdeath. sctor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of Month				
s that ned by deta	by Ph	Part II. Other significant conditions con	ntributing to death bu	it not resulting in the u	inderlying cause given in Part	I. 23e. Did	tobacco use contribu	ute to the cause of death?			
equire: en sig ould br	ed b	Laro navy	Near	+ our	jen	1 🗆	Yes 2 No 3	Probably 4 Unknown			
The law re ate has be bage 2 sho	Completed	,		remin	lia	24a. Was auto perfi 1 □ Yes	opsy pric ormed3 dea	re autopsy findings available or to completion of cause of th?			
cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?				e of Death (Check only	*	INCISÉ			
Physic this c	္	1 Yes 2 No		nt 2 ER/Outpatie		lursing Home 5 Res		(Specify) ALF			
ding I h. After funer	tion	27. Manner of Death 1	28a. Date of Injur (Month, Day	ry 28b. Time o (, Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □		how injury occurred	A NNA (4)			
To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	I iry - At home, farm, st :. <i>(Specify)</i>	reet, factory, office		(Street and Number wn, State)	or Rural Route Number,			
To the Hospital or within 24 hours afte To the Funerat Dir completely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best on ner: On the basis of and manner sta	examination and/or in	th occurred at the time, date an estigation, in my opinion, de	and place, and due to the eath occurred at the time	e cause(s) and manr e, date and place, and	ner as stated. If due to the cause(s)			
To the withing the the complex	Ž	29b. Signature and title of certifier	Ali	Aum	29c. License number	1438	29d. Date signed (I				
CHID		30. Name and address of person who co	LENTY	4 m 4	Print) 47 DEFEN	ISE HIGH	WAS Aa	wher 30 2009 WAPOLY MOLIY			
Sta	-	31. Date filed (Month, Day, Year)		ar's Signature	back		1				
Registr		JAN 04 2	JIV SEAM	m H. B							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roy B. Cowdrey Month December 2009 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Deat 4c. County of Death
Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug. 31, Funeral 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) 1 🙀 M 2 🗆 F Months Days 576-38-0884 88 Director Aug. Massachusetts Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Directo Anne Arundel Maryland Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 Bay Front Drive, #212 21403 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ★No Specify: Year or Dates. 1944-74 Specify: Completed 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Captain U.S. Navy 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marguerite Briand 1 and 2 should be filed if Health and Mental H item 27 is marked of Roy T. Cowdrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 Annette Cowdrey/wife 7101 Bay Front Drive, #212, Annapolis, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of Important: If ite any Injury or ot 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1/4/2010 Baltimore, Maryland 21. Signature of Tyneral Service Lice Soci 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ curd: omyopat disease or condition resulting in death) ischemic Medical Due to (or as a consequence of) Examiner croscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown P.O. ed by the Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Ner Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a dittle of certifie 29d. Date signed (Month, Day, Year,

C# 20+1

Box 68760

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

04

0 gistrar's Signature 58.510

12-31-09

2001 Medical Parkway Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month DECEMBER Physician/ KENNETH DOYLE CRESS 2009 DMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL FREDERICK MEMORIAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **№** M 2 🗆 F Days Hours (Month, Day, Year) Country) Virginia-231-38-8148 **Director** 75 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo MD Frederick 1 4 Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral USA 10183 Winsten Drive 21701 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. unknown 1 ☐ Yes 2 No Specify: Specify: white 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Home Improvement 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Habern Carrie Holbrook Cress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Cress Frederick 10183 Winsten Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 12/30/09 4 Donation 5 Other (Specify) Resthauen Memorial Gard 21. Signature of Funeral Service Line 22. Name and Address of Facility Resthauen Funeral Services (1501 Catactin mm. Highway Frederick, MD 23a. Part 1. Enter the dis shock, or heart failu se, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ecta disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ecurre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death ed by the a g Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e Hospital or Attending Physician: The law requires to 24 hours after death.

Puneral Director: After this certificate has been sign et end filled in by the funeral director, page 2 should be leted filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 2/25/2009 MOD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1 VA Myung Hee Dam 400 W. 31. Date filed (Month, Day Year) 32. Regis ar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death DECEMBER 25, 2009 ANN COPELAND 8.42 P TAMARA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 🔀 F (Month, Day, 47 6.1962 Maryland 10c. City, Town or Location 10d. Inside City Limits Frederick Frederick 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21701 USA 14. Bace - American Indian.

Funeral 219-84-3805 Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland 10e. Street and Number Funeral 200 East 16th Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify: "naturai", 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Quality Control Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Samue1 W. Breckenridge, Sr Ella M. Droneburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health P.O. Box 56, Frederick, Md 21705 Greg E. Copeland/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 12/30/2009 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licenses Day 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shields, or heart failure. List only one cause on each line. Immediate Cause (Final Valion Meunonia Physician/ disease or condition Medical resulting in death) Examiner hronic Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď Records, Completed has After this certification funeral director, p To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 4 hours after death.

-uneral Director: After the ed filled in by the funeral 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 00062223 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bolarum

32. Registrar's Signature

State Registrar

Physician/

Medical

Examiner

Electronics 20c. Location - City or Town, State Frederick, MD 21701 Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 126

Black, White, etc.

Specify: White

16b. Kind of Business Industry

Registrar

State

196 Thomas

Johnson DR

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

allians.

Ana Rubio MD.

31. Date filed (Month) Day (Year)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 29, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#10aperFH 1/5/10 FMW.MCO Certificate of Death 2. Date of Death Physician/ Jose Andres Moran Colindres 12:38 PM December 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery National Institutes of Health Bethesda, MD 5. Social Security Number Sex 1 X M 2 □ F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 0873 171996 Guatemala Director 13 none Usual Residence of Decedent should be filed within 72 hours and and Mental Hygiene.
and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 25a or 28a-f show arke event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Guatemala City Guatemala 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Colonia Roosevelt 4a Calle 11-31 01011 Guatemala 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Guatemalan If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Hispanic Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o Zonia Magaly Colindres Perez Maiko Leonel Moran Corzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maiko Moran/Father 4a Calle 11-31 Zona 11 Roosevelt Guatemala city Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Guatemal 4 Guatemala City, 01011 4 Donation 5 Other (Specify) Colina Cemeterio 1/12/2010 21. Signature Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street, NW Washington, DC 20011 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death intraventricular hemorrhage Physician/ disease or condition resulting in death) hours Medical Due to (or as a consequence of) Examiner 2 years 5m Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dua to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the red t þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy certificate Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD D0069443 December 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice M. Leung 10 Center Drive, Bethesda, Maryland 20892 2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment tificate			d Mental	l Hygiei	ne 2 N	ng	43438
			Decedent's Name (First, Middle	Last)			imouto	0, 5,			of Death			3. Time of Death
	Physicia Medic		Doris Rae Cros	5						Dec	th ember	^D 3 ^y 1,	2009	5:40 ам
	Examin	er	4a. Facility Name (if not institution,						ocation of De			4c. County		
			Bedford Court 5. Social Security Number		ome . Age (In yrs. Ia	est hirthday)	Si If Under 1		Sprir		of Birth		_	omery Dlace (State or Foreign
	Funeral Director		217-42-3739	1 □ M 2 X F	87	Yrs.			Hours Mi		28 ,	1922	Was	hington, DC
	d t	L	Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Loc	ation						1	0d. Inside City Limits
	arylan a-fsh fied a	Director		gomery		ilver								1 Yes 2 No
	or 28 e noti	قَ	10e. Street and Number	JOHIELY		TIVEL	10f. Zip C				10g.	Citizen of	What Cour	itry?
	s 23a ust b	Funeral	14803 Che	rry Leaf T	errace				2090	06		US	A	
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ! 🗙 No	"	Vas Deceden Yes, specify	/ Cuban,	Mexican, Pue	(Specify Yes o erto Rican, et	or No- c.)	Blad	ce - Americ ck, White, o : Whi	etc.
2	hour hatur dical	olete		t's Education st grade completed)		16a. Deced	ent's Usual C	Occupati	on ring most of พ	varkina	168	o. Kind of B	usiness Inc	dustry
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р 2	ed wil Hygie other ent, tt	Be	17. Father's Name (First, Middle, L	ast)		110111	emayer		8. Mother's N	Name (First, Iv	fiddle Maid			
Jan J	l be fil fental rked tic ev	욘	Preston C. M	•						nche Ca		on ountern	<i>-</i> /	
	and 2 should be file Health and Mental I tem 27 is marked o ther traumatic eve		19a. Informant's Name/Relationsh Gary D. Cross			19b. Mailin 1480	g Address (S Cher	Street and	d Number or i Leaf Te	Rural Route N errace	lumber, City , Sil	or Town, S ver Sp	State, Zip C pring	Code) ,MD 20906
more	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other 1 once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		toto C	lace of Disposemetery, crem	natory or other	er place)	Park	Date 1/4/2		Rock	,	wn, State , Maryland
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89	certification of the second of	Σ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			16					23d. Da	te of delive	ery
Rox	requires that the death certificate be been signed by the attending physici should be detached for use as the but	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 Pregna	rth 2 □ Feta int at time of d wn	leath 5	Other (spec					Мо	onth	Day Year
P.O.	that the	by Ph	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying cau	use giver	in Part I.	23e.	Did tobacc	o use conti	ribute to th	e cause of death?
Š	juires en sign uld be	ed b	Hypertensian, Pne	monia, Dysph	nagia, Fa	ailure T	o Thriv	re		_	1 🗆 Yes	2 X No	3 🗆 Prob	pably 4 🗌 Unknown
000	law rec has bee e 2 sho	plet								24a	. Was an autopsy			psy findings available inpletion of cause of
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<u>ta</u>	sician: The law certificate has birector, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🌁 No	Hospital:				Othor		heck only one				
<u>></u>	y Phys er this eral di	음	27. Manner of Death	28a. Date of	patient 2 injury	28b. Time of		. Injury a		Home 5 28d, Desc	Residence cribe how in			
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Division of Vital Records,	al or Atte s after de I Directo d in by th	Certificate;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Place of	Injury - At ho , etc. (Specify)	me, farm, stre)	et, factory, o	office			tion (Street or Town, St		er or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. Jo the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical E	Physician: To the best taminer: On the basis Nurse Practioner: To	of examination	and/or invest	igation, in my	opinion,	death occurre	ed at the time,	date and pla	ace, and due	e to the cau	ise(s) and manner stated.
	withi comp	٦	29b. Signature and title of certifier	un fina	100		29c. L	icense n				Date signed		
	5			undin				233.				Jan.	4, 20	TO
			30, Name and address of person v Shyamsundar Rajan	tho completed cause MD 9801 (of death (Item Seorgia 2	23a) (Type, P Avenue,	rint) Silver	Sprin	ng, MD 2	20902				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ COLE SUE 4:30AM ZARAH OFCEM3UN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Age (In yrs. last birtho If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🛣 F Months Hours VIRGINIA 66 Director 215-42-7499 Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at e, Zarah Director ANNE ARUNDLE CROFTON 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1629 PARKRIDGE CIRCLE APT 128 21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 🔀 No and Mental Hygiene. is marked other than "natural", If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Second 12TH onday (0-12) College (1-4 or 5+) ADMINISTRATIVE CLERK GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ WILLIAM WATSON JUSTIS GERTRUDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MARION COLE/HUSBAND 1629 PARKRIDGE CIRCLE APT 128 CROFTON, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD NATIONAL CEMETERY: 1/6/10 LAUREL, MARYLAND Signature of Furnal 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER, MARYLAND 20785 LANDOVER ROAD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Part 1 Enter the dise Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** (-ATA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 100 1 Yes 2 Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann P Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) 0055702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061 TSION BERHANE M.D. 31. Date filed (Month, Day, Year) State Registrar JAN () 5

DHMH 17 Rev 7/2009

		For State Registrar	State of iv	iaryiani	•	artment of F rtificate of		na ivien	tаі нус ғ	gienę Reg. Na	2009	9	43440
Physicia	ın	1. Decedent's Name (First, Middle,			61		_	1	Date of Dea Month	Day	Ye	ar	3. Time of Death
/Medic	al	Joseph	E.		Chas	4b. City, Town, o	v I continu of I		2/30	1	09 County of D)oath	10:40 a ^M
Examin	er	4a. Facility Name (If not institution, Calvert Mem.)							•		
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and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10	od. Inside City Limits
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	tor	Maryland Char	165		Wald	orf							1 ☐¥es 2 ☐ No
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rs aft	by F	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1□Yes 🛂 No	Specify:				Specify:	Bla	ak
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thould ind Me mark matic	7	Eugene 19a. informant's Name/Relationshi	p (Type, Print)			ng Address (Street	Luci		ute Numbe	er. City o	~	eer te. Zip	
and 2 s ealth ar n 27 is ner trau		Raymond Chase				Dennis							
s 1 ar of Hea		20a. Method of Disposition		20b. P	Place of Dispo	osition (Name of matory or other pla	ce)	Date		20c. Lo	cation - Cit	y or To	wn, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	censee		2	2. Name and Addre	ess of Facility						20608
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ysicle is cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatie	nt 3 DOA Oth		sing Home			6 □Other	Specify	y)
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 ☐ Homicide determin	Zee. Place of I	etc. (Specif	y)	reet, factory, office		281.	City or Tox	street ar wn, State	na Number (9)	or Hura	il Route Number,
spital	a C	29a. Certifier 1 Certifying	Physician: To the bes	st of my kno	wledge, dea	th occurred at the t	ime, date and	place, and	due to the	cause(s) and mann	er as s	tated.
n 24 h n 24 h ne Fui	Medical	(Check only 2 Medical E	xaminer: On the basis and manner		tion and/or in	nvestigation, in my	opinion, death	h occurred a	at the time,	date an	d place, and	d due to	the cause(s)
To the company of the	ž	29b. Signature and title of certifier	^ (¬		29c. Licens		52			te signed (/		
		ayen	V. C. 7	uro	V10.	-	5065			, -		0 -	2009
(25)5		30. Name and address of person v		death (Item		Print) GYF	JN C	- S	UNZA	NA	س رام س	25	7
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 26, 2009 **Physician** 11:14A M Zelda L. Dubin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day Ye If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** . 1933 Days 1 □ M 2 🖾 F Months Hours Min. Washington, DC 76 Director 577-46-4244 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified at Director 1 TyYes 2 □ No Silver Spring MD Montgomery the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 20906 USA 3210 North Leisure World Blvd #307 23a Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after der Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Experiment. 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Sachs Manus Lewitz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090619a. Informant's Name/Relationship (Type. Print) 3201 North Leisure World Blvd #307, Silver Spring MD Morris Dubin/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of h 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grds. 12/28/2009 Olney, Maryland 22. Name and Addres Edward Sagel Funeral Direction, INC 21. Signature of Funeral Service Licensee Molissa Greenhut 1091 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Due to (or as a consequence of): burialphysician Box 68760 Physician/Medical law requires that the death certificate the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 Tyes 2 No P.0. the 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? has e 2 s autopsy page certificate 1 □ Yes 2 XNo or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending I hours after death.
uneral Director; Af 1 □ Yes 2 □ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after
to the Funeral Directory Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) To the Med Dir 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Dr Olney 18101 charl JAN 04 31. Date filed (Month. 32. Aegistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department	artment of Health and I	Mental Hygie	2009	43442
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
-	Physici /Medic		Henry P. David		December	31. 2009	1010 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgo	ma w.r.
9	Funeral	•	Shady Grove Adventist Hospital 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0	place (State or Foreign
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	put 🔥		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	nation			0d. Inside City Limits
	Maryle f sho	ō	MD Montgomery Bethesd			'	1 XYes 2 □ No
	r 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	itry?
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	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ	
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ TYves 2 □ No If Yes, Give WW II Year or Dates:	1 □Yes 2 【XNo Specify:		Specify: Whi	
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Maryland 21215-0036	d be fi ental H ced ot c ever	Be	17. Father's Name (First, Middle, Last) Ferdinana David		ne <i>(First, Middl</i> e, <i>M</i> a <i>id</i> Gerson	ien Surname)	
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Baltimore,	of He fiter		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State 20b. Place of Disposemetery, crem	osition (Name of matory or other place)	Date 20c	. Location - City or To	wn, State
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event recting to notified at once.		21. Signature Mo1163	2. Name and Address of Facility ward Sagel Funera Rockville	Direction 20852	n 1091 Ro	ckville Pik
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
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Records,	w requir been s should	etec			24a. Was an	1	psy findings available
Re	The lar	Completed			autopsy performed	prior to con death?	mpletion of cause of
		Φ	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ☐X th (Check only one)	No 1 □ Yes	2X_JNo
	Physician: this certific al director,	70 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		ome 5 Residence	6 ☐Other (Specif	y)
Ĕ	ter ter nera	ü	27. Manner of Death 1 Natural 5 Pending	Work?	28d. Describe how in	njury occurred	
Division of	I or Attendir after death. I Director: At d in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stri	M 1 ☐ Yes 2 ☐ No	28f Location (Street	and Number or Rura	I Route Number
<u>></u>	pital or At burs after of eral Direc filled in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strubullding, etc. (Specify)	oot, rustery, onido	City or Town, St	ate)	Triodic Number,
	To the Hospital of Avithin 24 hours at To the Funeral D completely filled i	edical (29a. Certifier (Check only (Check only 2 Medicel Examiner: On the basis of examination and/or in	n occurred at the time, date and place	, and due to the cause	e(s) and manner as s	tated.
	To the Hos Within 24 ho To the Fun completely	Medi	one) and manner stated. 29b. Signature and title of certifier				
	12 68	_	290. Signature and title of certifier	29c. License number D0064235		Date signed (Month, sember 31,	
			30. Name and address of person who completed cause of death (Item 23a) (Type,				
			Joel Edward Buzy MD 9901 Medical Cent	er Drive Rockvill	e MD 20850)	
	Stat		31. Date filed (Month, Day, Year) JAN 04 2010 32. Registrar's Signature	20			
	Registra	ar	JAN 04 2010 Januar S. Aar	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Audrey Rose DENABURG 2009 3:45 A M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Assisted Living Sandy Spring Montgomery 5. Social Security Numbe 579–42–2803 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🎞 F Hours Feb. 21, Mary Tand Director 78 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouny or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Potomac Maryland Montgomery 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 8253 Buckspark Lane West 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home H**o**memaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ida Rubinstein Joseph Sherman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8253 Buckspark Lane West, Potomac, MD Kenneth Denaburg, Son Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition
1 \(\text{D}\) Burial 2 \(\text{D}\) Cremation 3 \(\text{D}\) Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State King David Memorial Garden 12/29/109 Falls Church, VA 5 Other (Specify) . Signature of Furberal Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington,
The Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronic Obstructive Pulmonary Disease Physician/ disease or condition resulting in death) Years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the oearn certineate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant Unknown Year Pregnant at time of death 5 Other (specify) 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's Disease, Hypertension, Coronary Artery 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Disease autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 Y No Hospital: 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Living 28d. Describe how injury occurred X Natural $5 \square$ Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Verember 28,2009 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brocks Hoffman, U.O. 18100 Slade School Koad 31. Date filed (Month, Day, Year) State JAN 04

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2009 7:30 A.M William . Dossev Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 8846 St. Andrews Drive Chesapeake Beach Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 03/26/1949 Washington, DC 220-54-1346 60 Director Usual Residence of Decedent or 28a-f shown notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or Funeral 8846 St. Andrews Drive 20732 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) non profit association accounting assistant of Health and Mental Hygie fitem 27 is marked other r other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Eugene Dossev Evelvn Regina McKinnon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Dossey, wife 8846 St. Andrews Dr., Chesapeake Beach. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If iter any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metropolitan Crematory 01-04-2010 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, Signature of Funeral Service Licensee Lam R-8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 Water disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ☐ Live Birth ∠☐ retail do...
☐ Pregnant at time of death in the past 12 months? Month Year 2 No certificate has been signed by the irector, page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 N 2 🗌 No 1 🗌 Yes 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 1 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 31. Date fled (Month, Day, Mi 32. Registra State

Registrar

JAN 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December ^{Day}5, Marilyn Daigneault 2009 2:30 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 4026 Manheim Court Jefferson Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Months 18, Director 259-48-1548 74 1935 Georgia item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Jefferson Maryland 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4026 Manheim Court 21755 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: white 3 X Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gaynelle Teems Charles Eichwurtzle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Tofferson Marvland 21755 19a. Informant's Name/Relationship (Type, Print) 4026 Manheim Court, Jefferson, Maryland Susan Riggs - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 1-19-2010 **Arlington National** Arlington, Virginia Denation 5 Other (Specify) ture of Funeral Service Lipensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Buser our nset and Death Physician/ ulmonen disease or condition resulting in death)) Medical Due to (or as a consequence of): Examine Stroke Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Cause Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year 1 ☐ Yes 2 lii 9 ☐ Unknown cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 X No Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 2 🗌 No after death Director: / ☐ Accide
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Toll

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1-11)

32. Registrar's Signature

Zerid!

31. Date filed (Month, Day,

D43091

12-28-2009

House Ane, Brederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 29, 2009 Physician 5;07A. Daniel Dwiggins /Medical 4a. Facility Name (If not institution, give street and number)
1016 Decesaris Drive 4b. City, Town, or Location of Death Lothian 4c. County of Death Examiner Anné Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Apr. | 19,1917 5. Social Security Number Sex 1 M 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Virginia 216-16-2720 92 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be a officed at Lothian Maryland Anne Arundel 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21711 Funeral 1016 Decesaris Drive United States 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event in any injury or other traumatic event increase. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify. ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Wesley Dwiggins Helen Utz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. Dwiggins -son 7218 Minter Place Takoma Park, Maryland 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 12/29/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA Dona 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Senile **Physician** Hdvanced disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Ye ar Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2X No 1 ☐ Yes 2 DXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

death. filled in by the

requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospital or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

9

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature applittle of certifier

29c. License number D31001 29d. Date signed (Month, Day, Year)

December 29, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Catt. Dr. #430 Tur ke wit 3 Greenbelt, MD

Registrar

Medical

31. Date filed (Month, Day, Year) JAN 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 24, 2009 **Physician** KENNETH D. DEWITT 1630 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE PRINCE GEORGE HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 6. Sex 1 2 M 2 □ F 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 12–20–1956 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months Min. NEWYORK, NY 116-48-5453 53 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD PRINCE GEORGE UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1512 SNOW GEESE CT 20774 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ NoNAVY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo BLACK Specify à Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2yrs COMPUTER OPERATOR PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ANNIE DODDS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. JUANITA D DEWITT/WIFE 1512 SNOW GEESE CT UPPER MARLBORO, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 01-08-2010 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Funeral Service Licensee 4 7474 LANDOVER RD LANDOVER, MD 20785 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: filled in by the 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day al Khen 23242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MOHAMMAD KHAN MD, 3001 HOSPITAL DR CHEVERLY, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Kenneth George 30 2009 8:42 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Montgomery 419 Russell Avenue #519 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 86 Director Nov. 8,1923 New Hampshire 578-38-9486 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1∭XYes 2 No MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 Russell Avenue #519 419 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 X No Specify: White 2 3 Widowed 4 Divorced Year or Dates: WW II Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Law Firm Comptroller 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othwany Injury or other traumatic event 17. Father's Name (First, Middle, Last) Ethel S. Spinney Turner H. Emery ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 419 Russell Avenue, #519, Gaithersburg, MD 20877 Jean H. Emery / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20c. Location - City or Town, State 20a. Method of Disposition December 30 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 Crematory 21. Signature of Euneral Se 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 der art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Weeks Immediate Cause (Final disease or condition resulting in death) Adult Failure to Thrive **Physician** /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, physician the burial by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Osteoarthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Osteoporosis 24a. Was an autopsy 2 □No 1∐Yes 2∭XNo 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Ϊ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 30, 2009 10+1 H. Robert Birschle 04115 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 201 Russell Avenue, Gaithersburg, MD 20877 H. Robert Birschbach, M.D., 31. Date filed (Month, Day, Year) Registrar's Signature State racked JAN 04 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	/larylar		artmen rtificate			and M		giene Reg. No	0.0	0.0	1. 2	110
	Physic	ian	1. Decedent's Name (First, Middle, L	· ·							2. Date of De Month		~ U	Vear	3. Time	of Death
-4	/Medi	cal	Florence Nicki 4a. Facility Name (If not institution, g	Eckerman							Decemb			όο̈́9	115	Р м
mark!	Examiı	ner	11817 Hunting Ric		r)			toma	Location o	f Death			County of Mont	of Death gome:	cv	
2	Funeral	Г		Sex 7. A	Age (In yrs.	last birthday)	If Under Months	1 Year	If Under 2		8. Date of Birt	th				or Foreign
	Director		579-30-4496 Usual Residence of Decedent	1□M 2ĂF	85	Yrs.	WOTHERS	Days	Hours	Min.	8/16/19	924	,	Wash	ingto	n DC
~	nand ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	Od. Inside (City Limits
1	a-fsh	ctor	MD Montgor	nery	Pot	omac									1 XYes	s 2□No
	th with the 23a or 28 ust by no	Funeral Director	10e. Street and Number 11817 Hunting R	idge Court			10f. Zip 20	Code 854				10g. Cit Uni	izen of W	hat Count State	ry?	
980	s within 72 hours after death with the Maryland giene. If than "natural", or items 23a or 28a-f show the Medical Eveninar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ∐Yes 2X If Yes, Give Year or Dates	?] No		Was Decede fYes, speci I □Yes 2		spanic Origin, Mexican, Specify:	gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)	-		America , White, e	tc.	
15-0	'natul	Completed	15. Decedent's E (Specify only highest g	Education rade completed)		16a. Deced	kind of work	k done di	urina most	of workir	na	16b. Ki	ind of Bus	siness/Ind	ustry	·
121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use	e retired)			.9	ъ.				
102	filed Hyg other ent, I	Be Co	17. Father's Name (First, Middle, Las			Teach	er / l		maker 18. Mother		(First, Middle,		ucat: Surname		Own	Home
/lar	2 should be and Mental is marked c	To B	Maurice Tolstoy	7					Carr	ie M	latthews	3		,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic esone.		19a. Informant's Name/Relationship Jerome Eckerman -			11817	Hunt	ing]	Ridge	r or Rura Cou	Route Number	er, City o	MD 2	State, Zip (20854	Code)	
more	Pages 1 nent of Hu int: If iten iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		20b. F Gar	Place of Dispos cemetery, crem den of emoria	sition (Name natory or oth Remet L Pari	e of her place nbrai K	nce		ate 2010			City or Tov		
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lies	nsee	м0116	3 E	Name and	Address Sag Roc	s of Facility e1 Fu kViII		l Direck	tio:	le Mi	3 208	552	
14			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the deat										Approxima Interval Be	te
in	Physician	i II	Immediate Cause (Final disease or condition		monia										Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	s a conseq	uence of):										
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	s a consequ	uence of):										
o o	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):										
	ificate by physical sthe bu	edical		d												
O. Box	he lay requires that the death certific are has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3□	Ectopic pre Other (spe					2	23d. Date Mont	of deliver th E		Y ear
rds, P.	requires that the diperior signed by the should be detached	þ	Part II. Other significant conditions	contributing to death I	out not resu	ulting in the un	derlying cau	use given	in Part I.		23e. Did to				cause of o	
I Records,	: he lay re cate has be page 2 sho	Completed								_	24a. Was a autops perfore	sy m <u>e</u> d?	pri de	ere autops for to com ath?	sy findings pletion of c	available cause of
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other			(Check only or	ne)				
ō	Phys er this eral dir	음	1 Yes 2 ANo 27. Mapper of Death	1 ☐ Inpati		ER/Outpatient 28b. Time of			4 L Nurs		e 5 Resid					
<u>o</u>	tending F leath. Ior: After the funera	atior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	ay, Year)	Injury	М	c. Injury a Work? 1 □ Ye	es 2∐Ne		8d. Describe h	ow injury	occurred	1		
Division of	spital or Atte ours after des ieral Directo filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		jury - At ho tc. <i>(Specif</i>)	me, farm, stre	et, factory, o	office		28	Bf. Location (Si City or Town	treet and n, State)	d Number	or Rural i	Route Num	nber,
:		edical (29a. Certifier (Check only one) 1 X Certifying Plants on the control of the con	nysician: To the best miner: On the basis of and manner st	ot examinai	wledge, death tion and/or inv	occurred at estigation, i	t the time n my opi	e, date and nion, death	place, a occurre	nd due to the o	ause(s) late and	and man place, an	ner as sta d due to t	ted. he cause(s	3)
	V V Mith	¥	29b. Signature and title of certifier	Will		ms	D29c. I	License r	number		2	9d. Date Janu	signed (Month, Da	0,10 Year)	
			30. Name and address erson who Gary Wilks, MD 64	completed cause of c	death (Item	^{23a)} (Type, P	rint) Lite 4	70 E	Bethe	sda 1	MD 2081	7				
	Stat		31. Date filed (Month, Day, Year)	32. Registi	ar's Signat	had	9									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 0899 1/26/2010 JH State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year DECEMBER 29 2009 11:10 F M Sandra L. Erwin 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Saint Agnes Hospital 1+more Birthplace (State or Foreign Country)
 TT. 5. Social Security 19243 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/23/1943 1 ☐ M 2 🔀 F IL323-36-9216 66 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits MD Calvert Owings 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20736 U.S.A. 6873 Bayberry Crossing 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) USPS Computer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Arnold Leanora Howerter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Becker/Daughter 6875 Bayberry Crossing, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem 01/25/2010

Arlington, VA 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Gary J. Goff 8125 Southern Md Blvd., Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 day disease or condition resulting in death) Due to (or as a consequence of): certifice atte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ion and dieletes Made Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? seral desease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No 24a Was an 2□No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Injury at Work? (Month. Day Year) 1 Natural 5 Pending investigation 2 Accident

Examiner The law requires that the death certificate be executed physician and is the burial-tran To the Hospital or Attending Physician: neral Director: / / filled in by the f

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

other than

is marked c

f Health item 27 i

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once.

Physician

/Medical

Director

Funeral

Completed by

Be

ပ

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be (Certification: To

Medical

Examine

IF FEMALE: 23b. Was decedent pregnant

3 ☐ Suicide

4 Homicide

25. Was case referred to medical			
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient	2 ER/Outpatient	3□ DOA
27. Manner of Death	28a. Date of Injury	28b. Time of	280

1 ☐ Yes 2 ☐ No

29c. License number

29d. Date signed (Month, Day, Year) December 30, 2009

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. AGNES HOSPINAL BATIMORE, MD 2122

dRW State Registrar

31. Date filed (Month, Day, Year)

ILLIAM

6 ☐ Could not be

FICKEN, M.D 32. Registrar Signature

JAN 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death December Physician/ 2009 Kenneth Steven Ermer 8:45 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 833 Yardley Drive Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In vrs. last hirthday **Funeral** 1 🕅 M 2 🗆 F 212-72-4214 Director Usual Residence of Decedent 28a-f shov 10b. County be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 ሺ No MD Anne Arundel Shady Side 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1226 Holly Avenue 20764 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever In U.S.

Armed Forces?

1 ☑ Yes 2 □ No

If Yes, Give
Year or Dates1976-79 Black, White, etc. "natural", or 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) bakery sales and managment permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumait. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Ermer Rita Delores Hall Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Ermer, wife 1226 Holly Ave., Shady Side, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 12/31/09 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, of Funeral Service Lice 🗸 ee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, ERONA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Exar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 1V0 Other: မ son's 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Crifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

10+1

State

3 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Mukesh Mathur, M.D.

TEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

110 Hospital Rd..

32. Registras Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

#305.

Prince Frederick, MD

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State of Maryland / Department of Health and Mental Hygiene 2 () () 9 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eva December 31, 2009 Evans 9:05 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 608 Drum Avenue Capital Heights Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖰 F Months Days Aug 17, 1929 577-36-2053 80 Washington DC Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Capital Heights 10e. Street and Number 10f. Zip Code "natural", or items 23a or idical Examiner must be n 10g. Citizen of What Country? Funeral 608 Drum Avenue 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗗 No δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Black If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Cafeteria Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Perry Powell Bertha Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela B. Evans (Daughter) 608 Drum Avenue, Capital Heights MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Arlington National 01/20/2010 Arlington, Virginia 21. Signature of Meral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, P.A. atricia alimore 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🗙 No Ectopic pregnancy Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia, Alzheimers Type Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Type Z 24a. Was an autopsy Hypertension this certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier NW) MB 11793 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRAMC 6900 Georgia Avenue, NW, Washington, DC Jay Wilder, MD, Date filed (Month, Day, Year) State JAN 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Josephine Dorothy Favali December 31, 2009 3:56 a_M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Nov. 15, 9. Birthplace (State or Foreign Country) Massachusetts 1 □ M 2 🕇 F Months Days Hours 031-01-4104 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7709 Oldchester Road 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2NO No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rocco DeLuca Jennie DeRoma DeLuca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Favali/Husband 7709 Oldchester Road, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Jan. 2 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, Virginia 21. Sign for of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or domp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar mass has a show any injury or other traumatic event, the Madical Examinar mass has a series.

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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10a. State

Funeral

Director

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List o			, 0,		Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosvero Due to (or as a conse	quence of):	iovascular.	Disease	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	·			
resulting in death) Last	Due to (or as a consect	quence of):			
iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of g □ Unknown	al death 3 Ectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not res	sulting in the underlyin	g cause given in Part I.		cco use contribute to the cause of death? 2 ☑ 170 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? ↑No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3 🗆			ce 6 ☐Other (Specify)
27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my know caminer: On the basis of examine and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and plaction, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier		2	29c. License number	29d	. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 04 2010

Robent

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rothstein 82. Registrar's Signature

10

Old Georgetown Rd., Bethesda, md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 10a,b,c,d,e,f, per inf., g899,01/29/2010dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Hallie Ferrence Dec 31. 11:15 AM 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 👿 F Months Days Hours 93 Director July 6, West Virginia 1916 54 5172 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location Greenbrier 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Mexical Examinar mast be notified at 10a. State Clinton White Sul Director 1 ☐ Yes 2X No MD P.G. P.O. Box 352 10f. Zip Code 24986 10e. Street and Number 10g. Citizen of What Country? 7520 Surratts Road 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n. Prison West Virginia College (1-4or 5+) Elementary/Secondary (0-12) 12 Laundry Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nena Taylor Spangler Layton Pickering Hanna ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heatth and Important: If item 27 is n any injury or other traun once. (Son) 12815 Brandywine Road, Brandywine, MD 20613 William Ferrence 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 5.2010 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenbrier Memorial Gardens Lewisburg, West Virginia 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old 21. Signature of Funeral Service Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, ket Ing L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Chronic Kidney Disease and inding physician a Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the Ö 9 Unknown 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Ves 214No 1 ☐ Yes 2 No 1 □Yes s after death.

I Director: After this certifice ed in by the funeral director, r Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R092979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road, Fort Washington, MD 20744 Betsy Blank, CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

lor Attending Physician: The law requires that the death certificate be executed after death.

Directors. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burish-transit Division of Vital Records, P.O. Box 68760,

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ng .	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c.	Injury at Work?	0 DN:	28d.	Describe how inj	ury occurred

5 Pendi investigation 1 ☐Yes 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 2010

29a. Certifier tectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 East 33rd Street

29c. License number

Baltimore, MD 21218

State Registrar

filled in by

Medical

To the Hospital within 24 hours a To the Funeral C

31. Date filed (Month, Day, Year)

27. Manner of Death

Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

JAN 20 2011



09-10032 Denise Vivian Fox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 43456

		1- For State Registrar		Certifica	ite of	Death				Reg. No.			
Physic	ian/	1. Decedent's Name (First, Midd	le,Last)					2.	Date of De	ath		3. Time of	Death
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21215-0036 and be filed within 72 hours after Mental Hygiene. marked other than "natural?" cevent, the Medical Examinal.	Be	Benjamin F. W							Ball				
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Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused the	death. Do not	enter the	mode of dying, so	uch as card	diac or re	spiratory ar	rest, shoc	k, or heart		nate Interval
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Division of Vital Records, P.O. Box 68760, within 24 hours alor entificate be executed within 24 hours alor earth certificate be executed within 24 hours alor earth. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, death	occurre	d at the time, date	and place,	, and due	to the caus	se(s) and i	manner as st	ated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 20, 2009 **Physician** A^{M} 9:20 Rachel Greenberg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Nursing & Rehab Montgomery Rockville 8. Date of Birth (Month, Day, Year)
October 5, 1915 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕅 F Hours Director 94 Massachusetts 025-09-4562 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 United States 12 Wonder View Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2K No If Yes, Give Year or Dates: Specify Specify: Caucasian þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales -12-Sales Associate permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked office any light or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Bloom Rose Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Wonder View Court North Potomac, MD 20878 Harvey A. Greenberg - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA King David Memorial Gardens 12/27/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, VA 22315 23a. Part1. Inter the disease, or complications that caused the veath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finai **Physician** Acute Cardio-Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Hypertensive Heart Disease Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Chronic Anemia Due to (or as a consequence of): Physician/Medical Pneumonia IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

requires that the death certificate be executed Box 68760. Ö Division or Vital Records, P.

28a-f show

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

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physician

filed within 72 hours after death with the Hygiene.

Baltimore, Maryland 21215-0036

or Attending ours after death.

neral Director: At filled in by the fur Hospital

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Shukla Gomez, M.D. 15225 Shady Grove Rd. Suite 208 Rockville, MD 20850

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

063232

29d. Date signed (Month, Day, Year)

10

(Check only

29b. Signature and title of certified

		1 - State of Maryland / Dep Registrar	artment of Health and N		ene	31.58
_	sician	Decedent's Name (First, Middle, Last) Helen Freeman Gulliford		2. Date of Death Month	Day Year 3.7	Time of Death
	edical miner	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death		4c. County of Death Prince George	
Fune Direct		5. Social Security Number 579–12–8813 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday, 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Feb. 5, 19	9. Birthplace (Country)	State or Foreign
e Maryland	Director	Usual Residence of Decedent 10a. State				side City Limits □Yes 2 🛣 No
with the Mi	I Dire	10e. Street and Number 5939 15th Avenue	10f. Zip Code 20782		g. Citizen of What Country?	
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportants: If then 27 is marked other than "natural", or items 23a or 28a-7 show my injury or other traumatic event, the Medical Emminer must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Vidow Year or Dates: 15. Decedent's Education (Give (Give Year or Dates: 16a. Decedent's Education	Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: dedent's Usual Occupation a kind of work done during most of work done during most of work DO NOT use retired)	pecify Yes or No- o Rican, etc.)	14. Race - American Inc Black, White, etc. Specify: White	
212 d withii giene.	omo.	Elementary/Secondary (0-12) College (1-4or 5+)	tive Secretary		Banking	
and be file ntal Hy ed othe	Be	17. Father's Name (First, Middle, Last) Leslie Lewis Freeman		ne (First, Middle, Ma	·	
aryla should and Mei marke	ို		ng Address (Street and Number or Ru	nia Amon Wr eral Route Number, (
and 2 eath a n 27 Is		Jay A. Gulliford, Jr./Son	6516 Prestwick Drive	, Highland,	MD 20777	
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 77 Is marked other than any injury or other traumatic event. Its Mary		1 to Burial 2 □ Cremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify) George Wash	matory or other place) Ja nington Cemetery 2	n. 4,	oc. Location - City or Town, Sindelight, Maryland	
Balt permit Depart Import	ouce.	21. Signature of Funeral Service Licensee	2. Name and Address of Facility rancis J. Collins Fune 00 University Blvd. W.	eral Home In , Silver Sp	ring, MD 20901	
B760, Cate be executed Examine physician and the bundarlariant the bundarlariant	dical Examiner	23a. Part1. Enter the disease, or chapfications that caused the death. Do not en shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiopulmonary Arrest Due to (or as a consequence of): Myocardial Infarction Due to or as a consequence of c		or respiratory arres	Inter Onse	oximate val Between et and Death hour
Box 6 eath certiff attending for use as	Completed by Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day	Year
rds, P quires that en signed b	ed by P	Part II. Other significant conditions contributing to death but not resulting in the understanding to death but not resulting nderlying cause given in Part I.		cco use contribute to the cau		
al Recc : The law re cate has be	Complet			24a. Was an autopsy performe	24b. Were autopsy fir prior to completi death? ☑No 1 ☐ Yes 2 ☐ N	on of cause of
Vita sician certifi	Be.	25. Was case referred to medical examiner? 1 ☐ Yes 2 INo Hospital: 1 ☐ Inpatient 2 IN ER/Outpatie	045	th (Check only one)		
Division of Vital Records, P.O. to the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. The to the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director, completely filled in by the f	Certifi	4 Homicide determined 28e. Place of Injury - At nome, farm, sti		City or Town,		
Fo the Hospital within 24 hours of the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, deat control on the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, dat	e and place, and due to the c	ause(s)
To th Vithin	M	29b. Signature and title of certifier V. Level V.	29c. License number 2 2 9 6 6		1. Date signed (Month, Day, 1) 2 30 2 00	
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Thomas H. Burgieres, MD 7300 Van Dusen	Print) Road, Laurel, MD 2070	7	, , ,	
	State strar	31. Date filed (Month, Day, Year) JAN 04 2010 32. Registrar's Signature	aled.			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43459 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 12:35 PM Georgiana Green Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Prince George's Doctors Community Hospital Lanham 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye April 05 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Country) New Director 579-50-7952 Yrs. Jersey Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 22 Ridge Road. 20770 u.s.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk U.S. Regulatory Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Joseph Green Ruth Canover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24-C Ridge Road, Kelly Green - Niece Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 01/05/2010 Brentwood, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Som Medical Due to (or as a consequence of Examiner Tobocco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending abusiness and the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month To the Hospital or Attending Physician: The law requires that the deal within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 1 🔲 Yes 2 🗌 No Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goodloes

State

Registrar

Registrar's Sign

Promise Trive Bowie MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Time of Death Gertrude GILLMAN **Physician** ^{Day} 29, December 2009 5:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 1604 Dublin Drive 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months 88 Missouri Director 496-18-0049 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar, ust by notified at Marvland Montgomery Silver Spring 1 Tyes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1604 Dublin Drive 20902 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Administrative Dept. of Mental Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Schwartz Sarah Hoffman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath an Important: If item 27 is a any Injury or other trausonce. Gerald Gillman, Husband 1604 Dublin Drive, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Judean Memorial Gardens 01/03/10 Olney, MD 21. Signature of Furteral Service Licenses Torchinsky Hebrew Funeral Home 0 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Failure **Physician** 2 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 12 Years Non-Hodgkins Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Osteoporosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 21 No certificate 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of P Hospital or Attending P 24 hours after death. Puneral Director; After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only To the lewithin 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 December 30, 2009 D 35996

DHMH 17 Rev 1/2001

State

Registrar

Linda M. Burrell, M.D., 2730 University Blvd., W. #400, Wheaton, MD

32 Registrar's Signature

30. Naice and address of person who completed eause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 04 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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			For State Registrar		State	of Maryla			ent of F ate of L	Health and Death	Mental Hy		000	0.0	1.0	11 (1
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	Physicia Medi		Mattie	A. Green							Month Decem	ber 1	9, 2009	'ear	7:	:45 p M
	Examir		4a. Facility Name (i	f not institution,	give street and nu	mber)				r Location of Dea	th	4	c. County of	Death		
			Souther 5. Social Security N		nd Hospita		- last bloth day		inton der 1 Year	T 1811 0411-			Prince			
	Funeral Director		578-50-	7625	1 □ M 2 Q F	7. Age (In yr	72 Yrs.	Monti		If Under 24 Hrs Hours Min		ay, Year,)	B. Birthp Count D	lace (State ry) .C.	or Foreign
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	h with nust I	ners	2311 B	rooks Dri	ve Apt. 201				20746			US	SA			
	deatl	Ē	11. Marital Status		Armod E			Was De	cedent of H pecify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	ı-	14. Race -	America White, e		
36	al", o		1 Never Mar 3 Widowed		ed 1 1 Yes If Yes, Gi Year or E			1 🗆 Yes	s 2 🗷 No	Specify:			Specify:			
Maryland 21215-0036		Completed		15. Deceden	t's Education		16a. Dece	dent's U	sual Occup	ation		16b.	Kind of Busi		Black ustry	
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ž	ould b d Mer mark matic	-	John Ja 19a. Informant's N	acob Gre				-			Mangrum					
Ma	2 sh h ar 7 is		19a. IIIIOIIIIaili S N		Green - d	aughtar				and Number or Ri Drive Apt .					ode)	
	ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical		20a. Method of Dis	position		201	o. Place of Dispo	sition (*	Vame of		Date		Location - Ci		wn, State	
Baltimore,	permit. Page 1 and 3 Department of Health Important: If item 2 any injury or other			☐ Cremation 5 ☐ Other (S)	3 Removal from Decify)		Rethel Way	,		church Dece	mhar 26 2000	ш.,	ntinatov	vn N	4D	
alti	permit. I Departm Importa any inju		21. Signature of Fu	neral Service Li							Sewell Fune				<u> </u>	
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C	Physician/ Medical Examiner		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	rt failure. List oi (Final	a	caused the deach line.	tratic (er the m	ode of dyin	g, such as cardia	c or respiratory a	rrest,			Approximation interval Be Onset and	etween
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00	ath certificate be executed attending physician and for use as the burial-transit	ज्ञ	resulting in death)	s Last	c. Due to	(or as a cons	equence of):									
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. Box 68760	To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent in the past 12 1 Yes 2 [9 Unknown	months?		Birth 2 🗌 F gnant at time	etal death 3		ic pregnanc (specify)	ey			23d. Date of Month		ry Day	Year
P.O.	that the	y P	Part II. Other signi	ficant condition	ns contributing to	death but not	resulting in the u	nderlyir	ng cause giv	en in Part I.	23e. Did	tobacco	use contribu	ite to the	e cause of	death?
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Records,	e law req e has bee ge 2 sho	mplet	Seit	eres							24a. Was	psy ormed?	pric dea	r to con	sy findings	available cause of
<u>=</u>	ificate or, pa	Be Co	25. Was case eferr	ed to medical					26 DI	ace of Death (Che	1 🗆 Yes	2 🖭	No 1 🗆	Yes :	2 🗆 No	
Vita	ysicta is cer direct	To B	examine??	□No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆	045	- ·	Home 5 Res	idence	6 C Other (Specify)		
of	ng Ph ter thi neral	te:	27. Manner of Deat 1 Natural	h 5 🗌 Pending	28a. Date		28b. Time of injury		28c. Injury work	/ at	28d. Describe			зреспу)		
ion	tendir eath. or: Af the fu	ifica	2 Accident 3 Suicide	Investig	ation		,,	М		Yes 2 No						
Division of Vital	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	Medical Certificate:	4 Homicide	determi	ned 28e. Place build	ling, etc. (Spec					28f. Location (City or To	wn, Stat	e)			nber,
	Hosp 24 hou Fune eted fi	edic	(Check 2	∴ Medical Ex	Physician: To the laminer: On the ba	sis of examina	tion and/or invest	igation,	in my opinio	n, death occurred	at the time, date	and plac	e, and due to	the caus	se(s) and m	nanner stated.
	To the within To the Sompl		only one) 3 29b. Signature and		Nurse Practioner:	TO THE DEST OF	my knowleage, c		curred at the 9c. License		ace, and due to t		(s) and mann ate signed (N			
	- > - 0		· Y					(MV	1511	\	/-	2/24/0		<i>y</i> , <i>y</i>	
			30. Name and add	ess of person w	ho completed cau	se of death (It	em 23a) (Type, P	rint)	11	24 7		./	100	0/	71	
diR	W 10		Micho	at Fr	0510V	15	13 SU	MC	45	Ka.	LINTO	1,1	LCL	40	13-	5
	Stat Registra	e ir	31. Date filed (Mont	n, Day, Year	29 2009	Registrars Sig	nature	lo	in as I	f		,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 12/17/2009 1512 M Madelyn Amelia Greathouse /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AAMC Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2√xF 577-46-5798 76 Director 6/14/1933 ŤΝ Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits MD Anne Arundel Millersville 28a-f sh notified 1 ☐ Yes 2XXNo Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r death with 899 Cecil Ave. 21108 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Ite Lry or other traumatic event, the Medical Examines ☐ Yes 2 🙀 No Yes, Give 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Answering Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be è Leroy Greathouse Madeline Malone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary R. Greathouse 29783 Adams Rd. Niece Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crematory 12/23/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puriral Service Licent 22. Name and Address of Facility Hardesty Funeral Home, P.A. Dan 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Immediate Cause (Final Physician Ulmonary resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as f 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the autopsy performed? Yes 2 24No 1☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

In Funeral Director: A

Inled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi 2 ☐ Medical Examiner and manner stated. 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year)

CHI

31. Date filed (Month, Day, Year) JAN 05 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. park

2001 Medical Pkwy. Annapolis, MD 21401

200

State

Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene. Phys M Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

		_ For	Plea										All Cop i ⁄lental F		•	gible.		
	•	State Registrar						C	ertific	ate of	Death	· · · · · ·		Reg.	No.20	09	4346	
hysicia Medic		1. Decedent's Name	4	E			51	LB					2. Date of Month		Day 3/	Year	3. Time of Death	VI
Examin	er	4a. Facility Name (if Mandrin (Chesape	eake		ice			Ha	rwood						y of Death Arun		
uneral rector		5. Social Security No. 213-50-417	72	6. Sex 1 🗆	м 2 Д F		e (In yrs. la)4	ast birthday Yrs.	Mont	hs Days	If Unde Hours	r 24 Hrs. Min.	8. Date of 10/21/		r))	g. Birth Cour Wash	place (State or Foreigntry) Ington, D.(n C.
1-f show Ted at	ctor	Usual Residence of 10a. State	10b. County		1 . 1		10c. City	, Town or I	Location			-					10d. Inside City Limit	
23a or 28a st be noti	Funeral Director	Maryland 10e. Street and Nun 1262 Defe						Gaille	10f.	Zip Code 21054						What Cou d Sta	ntry?	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ried	2. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	orces? 2 1	ver in U.S	3. 13	If Yes, s	specify Cub	Hispanic Or an, Mexica Specify	ın, Puerto	ecify Yes or N Rican, etc.)	lo-		ce - Americk, White,		
er than "natu the Medical	Completed	(Spe Elementary/Sec	15. Decede cify only high onday (0-12)				+)	(Giv life.	e kind of	use retired	during mos	st of work	ing		. Kind of E	Business In	dustry	
arked other atic event,	To Be	17. Father's Name (I Frederick									1		e (First, Midd ermill	lle, Maide	-	ne)		
ım 27 is m her traum		19a. Informant's Na	er/Daug					885	King	s Ket	and Numb reat	Driv	e, Dav	ridsc	nvil	le, M	D 21035	
rtant: If ite njury or ot		20a. Method of Disp 1 Burial 2 4 Donation	Cremation 5 Other (Specify)	emoval from	State	C	as Cr	ematory emat	or other pla . ory	þ	01/01	/2010	Edg	gewat		laryland I Home	
any ir		21. Signature of Fur	neral Service	Les se		-											MD 21037	
sician/ edical		23a. Part 1. Enter to shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List Final	r complic only one a.	cause on ea	ach line	De	w	nter the n	node of dyi	ng, such as	s cardiac o	or respiratory	arrest,		C	Approximate Interval Between Orset and Death	-
miner	ner	Sequentially list co	nditions, nmediate	S b.			consequ									1		
an and rial-transit	al Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying iinjury s	С.	Due to	(or as a	a consequ	ence of):										
physici the bu	edica			C d.														
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23	c. If yes, out 1 Live 4 Preg 9 Unki	Birth gnant a	2 🗌 Feta	I death 3		oic pregnar r (specify) _	су			-		ate of deliv	ery Day Year	
n signed by Ild be deta	by	Part II. Other signif	icant conditi	ons cont	ributing to d	leath b	ut not resu	ulting in the	e underlyi	ng cause g	iven in Part	t I.					he cause of death?	/n
ite has bee vage 2 shou	Completed												pe	as an atopsy erformed	?	prior to co death?	psy findings available impletion of cause of)
certifica rector, p	Be	25. Was case referre examiner?	ed to medical	Но	spital:					Ott	Place of Dea		k only one)			MA	While	-
: After this e funeral di	cate: To	27. Manner of Death 1 Natural 2 Accident	5 Pendi	ng gation	28a. Date		ν	ER/Outpat 28b. Time injury	of	28c. Inju	4 ∐ N ryat		ome 5 Re 28d. Describ				HOSPICE Hory	-
al Director ad in by the	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be			ry - At hoi . (Specify)	me, farm, s	street, fac	tory, office				n (Street Town, Sta		er or Rura	l Route Number,	
the Funera	Medical	(Check 2	Certifying Medical	Examine	r: On the bas	sis of ex	kamination	and/or inv	estigation	, in my opin	ion, death o	occurred a	t the time, da	te and pla	ace, and du	ie to the ca	use(s) and manner sta	ited
70		29b. Signature and	title of certifie	5	X 2	1	714			29c. Licens	se number	138		230	Date signe	Month,	Day, Year)	
-12		30 Name and addre	er J	who con	EN	11	in	44	, Print)	DER	ENZE	EH	6HW	MA	NNF	Pou	SMOLIKU	
Stat Registra		31. Date filed (Monti	JAN 04	201	0 32.	egistra	r's Signati	B. 19	back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State AMEND#20b, openFH, 1/6/10, BMW, McCo Registrar Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Grace Priscilla Ann 30, 2009 3:35 \mathbf{P}^{M} Dec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death P.G. Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 6-10-Months Director 58 Mass 028-42-2331 Usual Residence of Decedent show or 28a-f shove notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Suitland MD. P.G. Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funeral 72 hours after death with U.S.A. 3908 Regency Pkwy 20746 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Healthcare Nurse 4 Be Page 1 and 2 should be filed in ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be t Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Jeanette Barboza John G. Andrade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5211 Lansing Drive, Temple Hills, Md. Adam G. Allen, II /Son 20a. Method of Disposition 20c. Location - City or Town, State
Waldorf, Maryland
Suitland, Md. 20b. Place of Disposition (Name of Date Heritage Mem Cemetery 1/8/10 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 2. Name and Address of Facility Hackett's Funeral Chapel, Inc. Macket 814- Upshur Street, NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final sthma Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): 0 b struchu Examiner 07.0 pulmuning Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit KA HUZIO Cause (Disease or linjury 5 that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the sahould be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has filled in by the funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Tes 2 No 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work?
1 Yes 2 No Accident Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ~ D64055 2/31/00

Registrar
DHMH 17 Rev 7/2009

State

7503 Surratts Rd. Clinton, Md. 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

. Registrar's Signature

Eric McDonald,

JAN 05 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10c, 19b per fh g900 2-8-10 vt
State of Maryland / Department of Health and Mental Hygiene
aend 10b, per fh g901 3/11/10 TT

Certificate of Death

Reg. No. 2 0 9 Amend 10b, per 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 00AM 2009 hamon ean 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ice 8 Wyeen Annes nnes 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Year) 1 M 2 □ F Months Days 483-48-701 65 eb 21 OLUA Director Usual Residence of Decedent 10b. County Queen Anne's with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: if Item 23a or 28a-f show any Injury or other traumatic event, the Medical Exaction Exaction any Injury or other traumatic event, the Medical Exactions must be notified 1 ☐ Yes 2 No MD Funeral Director Marydel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. ROAC 21649 orner 60 Duhame Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Nes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No altimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HRMED FORCES Elementary/Secondary (0-12)College (1-4or 5+) U.S.A.F. msat, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ElverA Kamon GARDEIS ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City Town State, Zip Code) 21649 19a., Informant's Name/Relationship (Type. Print) MARCA Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State pital CREMPTOR Dover, Delaw Are JAN. 1.2010 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael J. Ambruso Funeral Dir. Inc. DoveA, De 19901 M00 841 Inllunc to hust Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PROSTATE CANCE **Physician** month METASTATIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) ned by the a detached for ☐Yes 2☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a.. autopsy performed? Ves 2 No After this certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 2 - NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 -Natural 5 ☐ Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Medical 29a, Certifie 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifier 09 Jeffry UKENS nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name Contre ville ROAD 21617 J. V14Eng mp 31. Date filed (Month, Day, Year) Registrar's Signature 32 State JAN Registrar

09-09893 James Gatling Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # State of Maryland / Department of Health and Mental Hygiene

2009 43466

		1- For State Amend#10fperFHCCDOHertficateld Registrar Amend#19AperFHCCDOH1/6/10bb 1. Decedent's Name (First, Middle, Last)	Propeath		Reg. I	No.	
Physici		1. Decedent's Name (First, Middle,Last)			Date of Death Month Date		3. Time of Death
dical Exami	ner	James Gatling			December 20	0, 2009	1226 hrs
		Facility Name (if not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Clinton	Location of Deat		4c. County of Death Prince George	e's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 578 56 0659 1 2 F 66 y	If Under 1 Yea Months Day rs.			MM/DD/YYYY) 9. Bir 4.1943 Foreig Co	thplace (State or Washington DC
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 9703 Williamsburg Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4XX Divorced Fyes, Give Year 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Unknown 19a. Informant's Name/Relationship (Type, Print) Sherese Sarese Gatling (Daughter) 19b. Maili Sherese Sarese Gatling (Daughter) 19b. Maili 19c. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Qonation 5 Other Specify: 21 St. of ture of Fineral Service Licensee 22.	r Marlbon 10f. Zip Code 2074 Ves. specify Cubar Yes, specify Cubar Yes 2 XX No ent's Usual Occupa most of working life tive Off M. St. S position (Name of ce other place) Cemetery Name and Addres	spanic Origin? (Son, Mexican, Puerto specify: Into (Give kind of a Do NoT use reference) Item of P 18. Mother's Name Kath et and Number or Sonetery. 12/28/2 s of Facility Le	work done tired) work done tired) resident e (First, Middle, Mairryn Gatlin Rural Route Numbe hington, Date 2	White, etc. Specify: B] Sb. Kind of Business/ Governmer den Surname) ng r, City or Town, State DC 20019 Oc. Location - City or Suitland, Home, nc	ces ican Indian, Black, Lack Industry Town, State , MD
Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerotic Cardiovascular Di Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	the mode of dying				Approximate Interval Between Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be executed reate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	Dropport at time of dooth	Other (Specify)	Ectopic pregr	23e. Did toba	cco use contribute to	Day Year the cause of death?
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed	25. Was case referred to medical	26 Plac	e of Death (Chec	24a. Was an autopsy performe	24b. Were a prior to death?	bably 4 Unknown utopsy findings available completion of cause of es 2 No
Vital I ysician: his certifi director,	Be	examiner? Hospital: 4 Innetion 2 FR/Outpetie		I Othor		esidence 6 Othe	
ision of Vital I Attending Physician: r death. rector: After this certifi by the funeral director,	ation: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time o	f Injury 28c. Inju	ury at Work? Yes 2 No	28d. Describe how		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director, I completely filled in by the fi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, str	eet, factory, office	building, etc.	28f. Location (Stre or Town, State		ural Route Number, City
Divi	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated					
	Ź	29b Signiture and title of certifier with the control of the contr	29c. Licen:	M.E.		9d. Date signed (Mo December 22, 2	
BS15		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111	Penn Street, I	Baltimore, MI	21201		
St Regist		31. Date filed (Month, Day, Year)	41				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Aaron Gantt			1- For State Registrar		of Maryland	_	artment o		nd Mental _	10	Reg. No. 2	00	9 4346	
Physi Medical Exa			Decedent's Name (First, Middle, Last) Aaron Ivan Gantt						2. Date of D Month Decemb			Day Year r 22, 2009 33. Time of Dea 0320 hrs		
								b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's			
Funeral			5. Social Security N			Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 24	Hrs. 8. Date of B		(Y) 9. Bir	thplace (State or	
Directo	or		577-96-1	1100	M 2 F		37 Yrs		ays Hours	Min. 05/15	5/1972	Foreig	ountry)Wash,DC	
any		-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits		
land f show	once.	٥	DC			Was	hingto						1 X Yes 2 No	
th the Maryland 23a or 28a-f show	ned at	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What 1462 Bruce Place SE 20020 USA								ntry?			
n with th	De noti	eral	11. Marital Status		12. Was Decede			s Decedent of I	Hispanic Origin?	(Specify Yes or N	o- 14. Rad	e - Ameri	ican Indian, Black,	
er deatl	r must	Funeral	Never Marrie Widowed	2 Married		2 🗶 No		Yes 2 X N	an, Mexican, Pue	erto Rican, etc.)		ite, etc. :Blac	a le	
tours aff	xamını	<u>ş</u>	15. Decedent's Ed		or Dates:	ompleted)	16a Deceden	t's Usual Occup	pation (Give kind fe. DO NOT use		16b. Kind of B			
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5-00 iled wit Hygien	tue wi		17. Father's Name (ַ	river	18.Mother's Na	ame (First, Middle,	DC GO Maiden Surnam		ment	
2121 uld be f Mental marked	c event,		Charles E. Gantt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									. Zip Code)		
MD id 2 sho alth and m 27 is			Charles	E. Gant	t,Sr/Fa		2502	Regal	P1., W	aldorf,	MD 20	0601		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho	in Laure	1	20a. Method of Disp 1 X Burial 2	Cremation 3	Removal from S	State	Place of Dispos crematory or oth	ner place)	"	Date	20c. Location	,		
altim mit. Pa partmen portant	in or		4 Donation 5 21. Signature of Eur			Нет		Mem. lame and Addre		2/29/09	Wald	orf,	, MD	
		1	MM0099 3821 14th St. NW, Wash., DC 20011 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva											
Physicia Illicaio Examine	ıl.		23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Complications of a gunshot wound to the torso Death											
Examine			or condition resultin	1 11 1	Due to (or as a con									
		<u>l</u>	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause Due to (or as a consequence of):											
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760, icate be	and only	/Med	F FEMALE: 3b. Was decedent p	pregnant in the	AMENDED 23a, 2 23c. If yes, outcome	27,28a ome of pregr	-f,perm	,E g903	5/3/10	TT	23d. Date o	f delivery		
Box 6876. The death certificate of the attending physical for the attendin	nac as	Clan	past 12 months?	?		at time of dea	oth -	al death 3 ner (Specify)	Ectopic pred	gnancy	Month	D	ay Year	
b. Box the death by the atte		≥ _	1 Yes 2 N		9 Unknown	ith but not re	esulting in the u	nderlying cause	given in Part I	23e Did to	phacco use cont	ribute to t	the cause of death?	
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate by ris after death. By Directors: After this certificate has been signed by the attending physic led in by the financial directors after the certificate has been signed by the attending physic led in by the financial directors after the certificate has been signed by the attending physic led in by the financial directors after the certificate has been signed by the financial directors after the certificate has been signed by the financial directors after the certificate has been signed by the attending physics.	3	2					g						ably 4 🗹 Unknown	
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Rec r: The L	Spd C		25. Was case referre	ad to modical				26 Plan	f Dth (Ch-	1 Yes		death? ✓ Ye	s 2 No	
Vital hysician this cert		Ď	examiner?		ospital: 1 Inpat	ient 2	ER/Outpatient		of Death (Che		Residence 6	Other:		
n of ding P. h : After	H		27. Manner of Death 1 Natural	5 Pending	28a Date of In (Month, Day)		28b Time of Ir		ury at Work? Yes 2X No		how injury occur was sh			
IVISIOR Or Attendather death Director:		ວ	2 Accident 3 Suicide	Investigatio	28a Place of I		1:50 am me, farm, stree			28f Location (Street and Numb	er or Run	al Route Number, City	
Di ospital hours a ineral I	1		Suicide Suicide or Town, State) 5507 Livingston Rd Oxon Hill, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and magnetic as stated.											
Division of Vital Rec To the Hospital or Attending Physician: The J within 24 hours after death To the Funeral Director: After this certificate if	l coile	j j	one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	, M	2							29c License number			29d Date signed (Month, Day, Year)		
			30. Name and address of person who completed cause of death (Item 23a)								U 9			
			Pamela E. S	outhall, MD	Assistant Med	lical Exar	miner 111	Penn Stree	et, Baltimore,	, MD 21201				
; Regi	Stat stra		1. Date filed (Month	Day, Year) 2010	32. Registr	ar's Signatui	park	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 28, 2009 8:36 AM Leslie Hankins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☑ M 2 □ F 088-38-7286 Director 62 Feb. 19, 1947 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19515 Frederick Road 20876 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Wes 2□No 1966-1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by Specify: 3 Widowed 4 Divorced White Year or Dates: 1969 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tile Installer Tile and Flooring Co. 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any injury or other traumatic event Be 17. Father's Name (First, Middle, Last) Leo Leonard Hankins Leneta Ruth Fisher Seaman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2360 Oaklyn St, N.E., Palm Bay, Florida 32907 19a. Informant's Name/Relationship (Type. Print) Leonard Daryl Hankins (Brother) Baltimore, 20b. Place of Disposition (Name of Springlery Crematory of Other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 30 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 Crematory 21. Signature of Funeral Service icensee 22. Name and Address of Facility DeVol Funeral Home, TRACUSTUR M01117 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal Bleed **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Ischemic Bowel Syndrome Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) the ☐Yes 2☐No 9 ☐ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Lymphocytic Leukemia 1 ☐ Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ∐Yes 2 ⊠ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760. Division of Vital Records, o 24 hours after death.

e Funeral Director: After the letely filled in by the funeral.

To the within 2 21

> State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

any

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MO 63623

29d. Date signed (Month, Day, Year)

12 -28-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Dav Year **Physician** Igen berg 2214 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Citv. Town, or Location of Death 4c. County of Death Examiner Medica nne Center mapolis If Under 1 Year | Vif Under 24 Hrs. | 5. Social Security Number 6. Sex 8. Date of Birth Month, Day, Dec 25, 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Wash. D.C. 88 1921 578-16-9666 Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Middeal Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Prince George's Suitland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a 5421 Henderson Way 20746 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ₹2 Yes 2 □ No If Yes, Give Year or Dates; 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: ò Specify: 3 ₩ Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government than, College (1-4or 5+) Elementary/Secondary (0-12) 12 Painter Department of Interior permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stesl William Frank Hilgenberg Anna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hilgenberg (son) 56 Radcliff Drive Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2010 Suitland, MD 21. Signature Funeral Se lica Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Lisa M. Nounts 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consour nce of): Examiner Dira Sequentially list conditions, Examiner Due to (or as a consequence of) rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 4 hours after death. 2 Accident investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the within 7 29b. Signature and title of certifier 29c. License number m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lew 5 Medical Parkway acianna raynham mD

Registrar

State

31. Date filed (Month, Day, Year)

32. Registra Signature

JAN 05 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2009 Betty Brokaw Hill 12:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Calvert Solomons . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Hours (Month, Day, Year) 04-25-1927 Director Virginia 579-30-3759 82 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD St. Mary's Co. Piney Point 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16291 Thomas Road 20674 United States items 2 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Examiner Black, White, etc ō 2 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify "natural", 3 ♥ Widowed 4 □ Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Retail Sales Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Windle Jessie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 66, Piney Point, Maryland 20674 Susan Hill (Daughter) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Metropolitan Crematory 12/28/09 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lige 22. Name and Address of Facility Rausch Funeral Home, P.A. 0. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cau, e on each line. Immediate Cause (Final Donset and D Physician disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical for use as s, outcome of pregnancy Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗆 Yes 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform certificate 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of hours after death uneral Director: After 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signatu

State Registrar

sper

31. Date filed (Month, Day, Year)

32. Registrar Signature

FoWEND#10a,b,c,d,e,f State of Maryland / Department of Health and Mental Hygiene Registraper FH 1/14/2010. CMH Certificate of Death Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ONALD 2'00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 1/13/1941 Illinoi 68 Director 359-30-8492 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be maritical once. oc. City, Town or Location Clearwater Beach 10b. County Pinellas 10a. State F**lorida** 10d. Inside City Limits Director 1 🗆 Yes 2 🗗 No Maryland Anne Arundel Annapolis 10e. Street and Number 1180 Gulf Blvd. Unit 1902 10f. Zip Code 10g. Citizen of What Country? 21403 USA 104 Fogle Drive 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 1963-65 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Economic Consultant/Developer Real Estate years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl Milton Hunter Florence Sterzik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia K. Hunter/ Wife 104 Fogle Drive, Annapolis, MD 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 12/31/09 4 Donation 5 Edgewater, MD Other (Specify) 21. Signature uner 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Part 1. En shock, or Immediate Cause (Final hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events transitor Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 1 💢 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 1ar

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles A. Heisler 2009 $\mathbf{P}^{\,\mathsf{M}}$ December 4:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Arnold** Examiner Anne Arundel Future Care Chesapeake Social Security Number If Under 1 Year If Under 24 Hrs. Date of Day, (Month, Day, 9. Birthplace (State or Foreign Country) unknown 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Davs Hours Year tXXM 2 □ F 67 510-16-6954 Director Apri Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Arnold Anne Arundel 1 🗆 Yes 2 🕱 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 305 College Parkway 21012 Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty Rhodes Charles Heisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2002 Clipper Park Rd., #108 Baltimore, MD 21211 Rose Ann Kirby/quardian Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Baltimore Crematory 1/4/2010 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur neral service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) day 5 5 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to cical Be 26. Place of Death (Check only one) examiner? Other: 2 No ျင 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of dertifier

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 860

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December HANNAH JR. AM NORMAN 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept 13, Year 1917 704-14-0853 1 X M 2 L F Hours Georgia Director 92 Usual Residence of Decedent 10b. County 10c. City, Town or Location . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The start: If item 27 is marked other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Frederick Maryland Mt. Airy 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4314 Molesworth Terrace 21771 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: white If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Rate Officer Southern Railway Be 17. Father's Name (First, Midaile, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarissa Williams Norman Jerome Hannah, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Raymond - daughter 4314 Molesworth Terrace, Mt Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 12-30-2009 4 Donation 5 Other (Specify) Pine Grove Cemetery Mt. Airy, Maryland Signulure of Funeral Service Lie 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Marylad 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ater disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 **X**No 은 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛮 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MDD35106

Registrar
DHMH 17 Rev 7/2009

State

31, Date filed (Month, Day,)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myung Hee Nam, 400 W. 7th Street, Frederick, Maryland

32. Registrar's Signature

12/25/2009

21701

09-09834 Randall Ray Hart Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra I. Decedent's Name (First, Middle,Last) 2. Date of Death Physician. Month Day December 18, 2009 0726 hrs Randall Ray Hart 4a. Facility Name (if not institution, give street and number)

Fishers Lane (Adennes Avenue) 4c. County of Death 4b. City, Town, or Location of Deat Rockville -Smithsburg Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1965 Director November 3, Maryland 218-82-8806 44 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Ob. County Yes 2 X No Washington Fairplay 28a-f show Maryland or items 23a or 28a-f shormust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21733 USA 9121 Jordan Road ā 14 Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funera 11. Marital Status White, etc. Armed Forces' 1 Never Married 2 X Married 2X No Yes If Yes, Give Year Yes 2 X No specify: Specify white Divorced Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Medical marked other than 12 Machine operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, the Patricia Caldwell Ralph Hart Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is Myrtle Christine Hart - wife 9121 Jordan Road, Fairplay, Maryland 21733 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) or other 1 🗶 Burial 2 Cremation 3 Removal from Stat 12-23-2009 Frederick, Maryland Resthaven Memorial Other Specify Donation 5 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service ≠icenses 21702 1621 Opossumtown Pike, Frederick, Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Blunt Force Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of). If any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED #4a&b&28F Per Me G899 1/20/2010 JH UNPENDED ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? ✓ Yes 2 1 V Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner Hospital: Other Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 this 1 V Yes 2 28d. Describe how injury occurred 28a. Date of Injury Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Pedestrian struck by truck Dec 18, 2009 0715 hrs Natural 1 ✓ Yes 2 No Pending 2 ✓ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number of Rural Route Number, City or Town, State) **5700 Fishers Lane** 3 Could not be Suicide determined (Specify) Construction Site Rockville MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 19, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. 31. Date filed (Monto 32. Régistrar's Signature State arks

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Gal Start

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SYLVIA ODEN HAMMOND December 2009 10:30 A /Medical 31 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 159 Willowdale #13 Frederick Frederick 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Months Days Hours Min Director 219-34-5596 17,1937 Maryland Isn. Usual Residence of Decedent death with the Maryland 10a State 10b. County show 10c. City. Town or Location 10d. Inside City Limits th and Mental Hyglene. ?7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Evandrer must be notified at Director 1 MYes 2 □No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 159 Willowdale #13 Funeral 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Doctor's Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be file If Health and Mental H tem 27 is marked oth Be William Harrison Oden Antonina Santangleo ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce D. Hammond/ Son 159 Willowdale #13, Frederick, Maryland permit. Pages 1 and Department of Healt Important: If item 2 any injury or other injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) urs Crematory 1

22. Name and Address of Facility Smithsburg, Marvland 1/2/1021. Signature of Funeral Service Licen Robert E. Dailey & Son F.H., P.A. Kute North Market St., Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4-5month disease or condition resulting in death) Panc Cotic cancer /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by icate has been sig , page 2 should b 1 🔲 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemi autopsy perform certificate Division of Vital 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No . After this certification of the thick of t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier соmpletely one) within 2 29b. Signa title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/3/109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Thomas houson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Byl BEAM

09-09949 John Joseph Haren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		109 434/1						
Physicia dical Exami	an/	1. Decedent's Name (First, Mic				2. Date of De Month Decemb	Day Year Per 21, 2009	3. Time of Death 1947 hrs		
>		4a. Facility Name (if not institu Howard County Gen	· =			ty, Town, or L olumbia	ocation of De		4c. County of Howard	
Funeral Director		5. Social Security Numberun	7. Age	(In yrs. last birtho		Under 1 Year onths Days	If Under 24I	Hrs. 8. Date of I	Birth (MM/DD/YYYY) 29,1959	Birthplace (State or Foreign Country) Unk
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street end Number 6045 Bauman 11. Marital Status 1 Never Married 2 3 Widowed 4 December 15. Decedent's Education (Specific Secondary (0-12 unk) 17. Father's Name (First, Middition 19a. Informant's Name/Relation 0 . C . M . E . 20a. Method of Disposition 1 Burial 2 Crematic	In Drive Unk 12. Was Decedent E Armed Forces? 1	No unk Dieted) 16a. De du	13. Was Dec If Yes, sp 1 Yes ecedent's Usuring most of U Mailing Add 111 Pe Disposition of y or other pl.	zip Code zedent of Hisp pecify Cuban, 2 X No sual Occupation working life. I zess (Street enn Str Name of cem ace) and Address of Anato	Mexican, Pue specify: on (Give kind on NOT use of the specify specify) 8.Mother's Na and Number of eet Ba etery, of Facility omy Boa	me (First, Middle or Rural Route N 11timore Date	White, Specify: 16b. Kind of Buse, Maiden Surname) umber, City or Town MD 212 20c. Location -	A - American Indian, Black, , etc. white siness/Industry unk unk
To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide 29a. Certifier 29a. Certifier 1 Certifying	as on each line. se a. Cardiac Arrhythn Due to (or as a consect b. Dilated Cardiome Due to (or as a consect d. AMENDED 23c. If yes, outcom 1 Live birth 4 Pregnant at ti 9 Unknown glitions contributing to death all Hospital: 1 Inpatien Leal Robert Sea. Date of Injur (Month, Day, Yes) 28e. Place of Injur (Specify) Physician: To the best of my caminer: On the basis of exam and manner stated.	nia quence of): egaly quence of): quence of): e of pregnancy me of death 5 [but not resulting i t 2 ER/Outp y ar) 28b. Tii liny - At home, fam	Fetal de Other (in the underling patient 3 me of Injury) The street, factors of the occurred at the occurred a	ath 3 Specify) ying cause give 26.Place of DOA 28c. Injury 1 Yestory, office but the time, date	Ectopic prequent in Part I. of Death (Che Dither Nur at Work? es 2 No ilding, etc. e and place, a death occurre	23e. Dic 1	23d. Date of of Month I tobacco use contrib Yes 2 No 3 Is an 24b. Work formed? Is 2 No 1 Residence 6 e how injury occurre (Street and Numbe, State) Use(s) and manner ite and place, and divided	Between Onset and Death delivery Day Year Dute to the cause of death? Probably 4 V Unknown Were autopsy findings available rior to completion of cause of eath? Yes 2 No Other: def or or Rural Route Number, City as stated. ue to the cause(s)
		30. Name and address of personal Carol Allan, MD A	on who completed cause of de ssistant Medical Exam		enn Stree		1.E. re, MD 212	201	December 2	zz, 200 9
St Regist	G. 5-G	31. Date filed (Month, Day, Yea	r) 2. Registrar	s Signature	em street	- Damino				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day **Physician** Bertie Clinton Hicks 11:03 a December 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4435 Harvest Lane Huntingtown Calvert 1 Year | If Under 24 Hrs. Days | Hours | Min. If Under 1 Months [5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Director 78 MD 214-58-1345 February 23, 1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 4435 Harvest Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married I □ Yes 2 X No f Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2A No Specify þ 3 Widowed 4 Divorced Year or Dates: "natural", Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housekeeper Apartments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hicks ပ Mary Chase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greta Holland - Niece 4435 Harvest Lane, Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or otl 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ernestine Jones Cemetery January 5, 2010 Chesapeake Beach, MD 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licenses Glader a 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) rtenoscleratio /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home SA Residence 6 Other (Specify) Hospital: 2X No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: 24 hours after death within 2

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Prince Frederick MD

State Registra

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For _ State	State	of Marylan							2000	10170
		1 - State Registrar Certificate of Death Reg. I 1. Decedent's Name (First, Middle, Last) 2. Date of Death										2003	434/0
	Physici	an		· · ·						Month	Day		3. Time of Death
×.	/Medic	cal	Aiden Michael				4h City Tayun	- Location	of Dooth	12-20		County of Dea	12:50pm ^M
	Examin	ıer	4a. Facility Name (If not institution Holy Cross	_	nurriber)		4b. City, Town, o		or Death				
			5. Social Security Number	Hospital	7. Age (In yrs. i	last hirthdav)	Rockv		24 Hrs.	8. Date of Bir		Montgom 9. Bir	thplace (State or Foreign
	Funeral Director		none	1 🛣M 2□ F		Yrs.	Months Days	Hours 1	Min.	8. Date of Bir (Month, Date 12-20-		Co	ckville
			Usual Residence of Decedent					<u> </u>		12-20	_200.	y KO	CKVIIIE
	yland		10a. State 10b. County	/	10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Ma-f s	cto	MD Prin	ce George	es Bi	ladensi	ourg						1 □Yes 2 □ No X
	or 28	Sire	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Co	ountry?
	23a	Funeral Director	4251 58th Ave	, #9			207					ited St	ates
	r des tems	nue	11. Marital Status	Armed	ecedent Ever in U.: Forces?	S. 13.	Nas Decedent of I f Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spe n, Puerto F	cify Yes or No Rican, etc.))-	 Race - Ame Black, Whit 	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than madical Examinat roust be redified at	by F	1 X Never Married 2 Mar 3 Widowed 4 Divorce	If Yes,	s 2∏XNo Give		1⊡Yes 2∏XNo	Specify	:			Specify: B	lack
9	hour tural	be t		nt's Education	r Dates:	16a Dece	dent's Usual Occu	nation			16h Ki	ind of Business	
15	in 72	plet	(Specify only highe	est grade complete	<u> </u>	(Give	kind of work done	during mos	st of workin	ng	100.10		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
212	with jiene r tha	Completed	Elementary/Secondary (0-12)	College	e (1-4or 5+)	Noi	ne				١,	None	
ğ	othe othe	BeC	17. Father's Name (First, Middle	, Last)				18. Moth	er's Name	(First, Middle			
lar	ald be Aenta rked tic ev	To E	Raumaund John	son				Sì	nawnna	a Artis	3		
Maryland 21215-0036	shou and N	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree	t and Numb	er or Rura	l Route Numb	er, City o	or Town, State,	Zip Code)
	and 2 salth 127 i		Shawnna Artis/	Mother		425	l 58th Av	7e, #9	Blac	densbu	rg, N	ID 2071	0
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	0 D D 1 6	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other pla	ice)	D	ate	20c. Lo	ocation - City or	Town, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (\$		Na Na	itiona]	L Cremato	ory	12/2	7/09	Fa	alls Ch	urch, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		22	. Name and Addr	ess of Facil	ity Jos	seph Ga	awle1	r's Son	s, INC
ш_	8 5 5 8 8		My life	Muy		5.	130 Wisco	onsin	Ave,	N.W.	Vash	ington	OC 20016
			23a. Part 1. Enter the disease of shock, or heart failure.	r complications in a tonly one cause or	at caused the death n each line.	n. Do not ent	er the mode of dy	ing, such a	s cardiac o	r respiratory a	ırrest,		Approximate Interval Between
P.	Physician		Immediate Cause (Final disease or condition	Can	rdiac Arr	rest							Onset and Death
أممي	/Medical Examiner	١.	resulting in death)		to (or as a consequ								
•	Lxammer	_	Sequentially list conditions,	D	vere Prem		У						
5	led isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z Due 1	to (or as a consequ	uence ot):							
ע	and and II-trar	Examiner	that initiated events resulting in death) Last	c	to (or as a consequ	uence of):							
8760,	iicate be executed physician and s the burial-transit	E E			,	,							
	ficate p phys s the	edical		d									
Вох	Physician: The law requires that the death certific this certificate has been signed by the attending print director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna							23d. Date of de	livery
m	death e atte d for I	icia	in the past 12 months? 1 □ Yes 2 □ No	4 □ Pr	ve birth 2 ☐ Feta egnant at time of c		⊒Ectopic pregnan ⊒Other <i>(specify)</i> ₋	cy			İ	Month	Day Year
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S, F	res tha signed be det	by P	Part II. Other significant condit	ions contributing to	death but not resu	ulting in the u	nderlying cause gi	ven in Part	1.	23e. Did	tobacco ı	use contribute t	o the cause of death?
rg	w require been sign should b	edit								1 🗆	Yes 2	No 3□F	robably 4 🗌 Unknown
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of Vital	hysician: The la his certificate ha: I director, page 2	Be C	25. Was case referred to medica examiner?					26. Plac	e of Death	(Check only			
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n c	ing P	on:	27. Manner of Death 1 Natural 5 □ Pendi		ate of Injury Ionth, Day, Year)	28b. Time of Injury	Wo	rk?		28d. Describe	how injur	ry occurred	
sio	Vttendi death. ctor: A	cati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	igation not be				Yes 2					
Division	after of Direct	Certification: To	4 ☐ Homicide determ	mined 200. Fla	ace of Injury - At ho ilding, etc. (Specif	ome, tarm, str	eet, factory, office		2	City or To			ural Route Number,
	pital Durs a eral I		29a. Certifier 1 Certify	Physician: To	the hest of my kno	wledge deat	h occurred at the	time date a	and place :	and due to the	e cause(s	and manner	as stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		I Examiner: On the									
	Nithin No the	Me	29b. Signature and title of certific		^ 1		29c. Licen	se number	. /		29d. Da	te signed (Mon	th, Day, Year)
			L LA	coll	27		D	3126	03		12	120	109
			30. Name and address of person	n who completed ca	ause of death (Item	n 23a) (Type,	Print)					1	\ -
_			Richard N. F	ooter, 15	00 Fores	t Gler	Rd. Roc	kvill	e, M	20910)		
	Sta		31. Date filed (Month, Day, Year) 32	Registrar's Signa	ture	del						
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 nt's Name (First, Middle, Last 2. Date of Death 3. Time of Death EXFERSUN Physician/ Month Ygar O 0321M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 Months Hours (Month, Day, Year) Director 218-28-2195 79 February 1, 1930 MD Usual Residence of Decedent Show 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 23a or 28a-f 1 🗆 Yes 2 🗶 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Valiant Circle 21061 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. "natural", Specify 3 Widowed 4 Divorced Completed Year or Dates Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Wallace - daughter 303 Valiant Circle, Glen Burnie, MD 21061 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Patuxent UMC Cemetery: December 28, 2009 Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Ilac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between shock, or heart failure. List only one cause on each line RSA Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of);
SACRAL Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 🗌 in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate I performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injurv 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License numbe

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Registrar
DHMH 17 Rev 7/2009

Name and address of pers

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31. Date filed (Month, Day, Year)

7 V V

who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Evelyn U. Johnson 2009 Medical 11:20A^M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crescent Cities Center Hyattsville Prince George's Funeral Social Security Number 6. Sex . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕱 F Months Days Hours Min (Month, Day, Year) 01/03/192 Director 263-22-0202 87 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits NONE 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 16th St. NE 20002 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 1 Yes 2 Baltimore, Maryland 21215-0036 2 x No 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 ☐ Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 7/ it of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Dispatcher Wash. SheratonHotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Booker Sweeting Sr. Ruth Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 Doncaster Dr. Ellicott City, MD 21043 <u>Betty Miller/Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/31/2009 Brentwood. Signature of Ameral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events the attending physician and the burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a Ectopic pregnancy in the past 12 months? detached for Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed' Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 1 Yes ျပ 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 K Natural 5 Pending Accident Investigation in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Ortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F 3 only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 1.0

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Saad<u>ia Husain 4409 East West Hwy,</u>

31. Date filed (Month, Day, Year)

D0064208

Riverdale MD 20737

12/31/2009

09-09980 Cathy Denise Jack	reon		or Print in Black In e of Maryland / Depa								
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Physician/ Medical Examine	1. Decedent	t's Name (First, Middle,Lathy Denise	Jackson		4. co. T	La college of D	Ď	oate of Death Month ecember	Day 22, 200		3. Time of Death 1214 hrs
<i>J</i>	,	Name (if not institution, e George's Hospita	give street and number)		4b. City, Town, o	or Location of D	eath			ounty of Death nce George	
Funeral Director			Sex 7. Age (In yrs. la	ast birthday) Yrs	If Under 1 Ye Months Da		16.	Date of Birth		Col	hplace (State o r Fioրդոi ջ untry)
any	Usual Resid	dence of Decedent 10b. County	10c. City,	Town or Local	tion						10d. Inside City Limits
rland -f show once.	MD		e George's Si	uitland				140	- 0'4'	of What Coun	1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	420	_{and Number} 1 Vine Stre	et		10f. Zip Code	0746		10	•	USA	iu y :
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital S	Status Un er Married 2 Marri	ed Armed Forces?	S. 13. Wa	as Decedent of H es, specify Cuba				14.	White, etc.	can Indian, Black,
s after d	2		ed If Yes, Give Year	1	Yes 2 ^X N			. naki		eciry:	ack
72 hours n "natural Exam	15. Deced	ent's Education (Specify ary/Secondary (0-12)	conly highest grade completed) College (1-4 or 5+)	16a. Deceder during m	nt's Usual Occupa nost of working lif	ation (Give kind e. DO NOT use	d of work e retired)	done	16b. Kind	l of Business/Ir	ndustry
5-0036 led within 7 Hygiene. other than the Medica	unk	Name (First, Middle, La	unk		unk	18.Mother's N	lomo /Ein	at Middle M	oldon Cur	mama)	unk
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MD 21 d 2 should th and Mer n 27 is mar numatic ev	19a. Informa	ant's Name/Relationship $\mathbf{M} \cdot \mathbf{E} \cdot$	(Type, Print)		g Address (Stre Penn St					or Town, State, 21201	, Zip Code)
Ore, leges 1 and to of Healt to of Healt is: If item wher tran	1 Buria		3 Removal from State	Place of Dispos crematory or ot	sition (Name of co her place)	emetery,	Da	te	20c. Loca	ation - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Injury or other tr	4 Dong 21. Signatur	re of Funeral Second Specific Specific Second Secon	ify: in state censee War piractor	²² S t	Name and Addres	ss of Facility Comy Bo	ard	655 W	. Bal	timore	Street
Physician	23a. Har I.	Enter the disease, a co	fications that caused the death.	Do not enter t	altimore he mode of dying	MD 2 g, such as cardi	1201 ac or res	piratory arres	st, shock,	or heart	Approximate Interval
/Medical Examiner	f Mure.	List only one cause on Cause (Final disease resulting in death)	a. Hypertensive a Due to (or as a consequence of	atheros							Between Onset and Death
	Sequentiall	y list conditions,	b			=					
ted nasit Examiner	if any, leadi cause. Ent (Disease or	ng to immediate er Underlying Cause injury that initiated	C. Due to (or as a consequence of Due to (or a) (or as a consequence of Due to (or a)								
ecuted and - transit		Iting in death) Last	d.	<i>).</i> 							
	M PINIOR				g899 1,	/28/10	TT		Coo . s		
ox 68760, ant certificate be e attending physician or use as the burial Sician/Medis	IF FEMALE 23b. Was de past 12	: cedent pregnant in the months?	23c. If yes, outcome of pregr	2 Fe	etal death 3	Ectopic pre	egnancy			ate of delivery nth D	ay Year
Box 68760, te death certificate be the attending physic reference as the burnary flyysician/Med	1 Yes	2 No 9 Unkno	wn 9 Unknown	ath 5 Ot	her (Specify)						
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cords, law require has been si e 2 should b	-						_	24a. Was ar			opsy findings available ompletion of cause of
Records, The law requires ficate has been sig., page 2 should be Completed								perform 1 V Yes 2	ned?	death?	s 2 No
Vital Recysician: The ysician: The his certificate director, page	25. Was cas examine		Hospital: 1 Inpatient 2	ER/Outpatient		of Death (Ch	eck only ursing Ho		Residence	6 Other:	
n of Viting Physical directions on; To		of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Inj	ury at Work?	28d	Describe ho			
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completed	1 X Natu 2 Acci	ident Investig	ation 28e Place of Injury - At ho	ome, farm, stree		Yes 2 No		Location (St	reet and h	Number or Rur	al Route Number, City
Division o Hospital or Attending A hours after death Funeral Director: After tely filled in by the fune al Certification;		nicide determi	ned (Specify)					or Town, Sta			
To the Hos within 24 h To the Fun completely	(Check only one)	Certifying Phys	sician: To the best of my knowledger: On the basis of examination are and manner stated.								
Me T S S S S S S S S S S S S S S S S S S	29b. Signate	and title of certifier	15 4			se number				signed (Moni	
	30. Name ar	nd address of person wh	no completed cause of leath (Item								
		lah Ali, M.D. As	sistant Medical Examiner 32. Registrar's Signatu		n Street, Bal	timore, MD	21201				
State Registra	~	JAN 2 C		1. 60	all!						
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Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

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	•	For State Registrar				,	•	tificate of			Reg. N		100	12102	
		1. Decedent's Nan	ne (First, Middle,	Last)						2. Date of Death Month Day Year 3. Time of D					
Physicia /Medic		Estelle	Jones							Decem			Year)	6:30 p ^M	
Examin		4a. Facility Name	(If not institution,	give street and num	ber)			4b. City, Town, or	r Location of De	ath	4	c. County	of Death		
			airground R				11 11 1	Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State							
Funeral		5. Social Security I		. Sex 7 1 ☐ M 2 🔀 F	Age (In yrs. last bir.		Months Days	Hours Mi	n. (Month, E	ay, Yea		Cou	place (State or Foreign intry)	
Director		215-74-2 Usual Residence				51			L	Decemb	er 30,	1958	N	1D	
yland how	.	10a. State	10b. County		10	0c. City, Towr	n or Loca	ation						10d. Inside City Limits	
th the Marylar or 28a-f show or rediffed at	Director	MD	Calver	t		Prince	Fred	derick						1 □Yes 2 No	
ith th	Dire	10e. Street and Nu	umber					10f. Zip Code				Citizen of	What Cou	ntry?	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examinar must be redified at	eral		irground R	oad 12. Was Deced	lont Eur	in II C	12 W	20678 as Decedent of H	lionania Origin?	(Charify Vac or N	US		a Amori	ican Indian,	
ter de Item	Funeral	11. Marital Status	rried 2 Marrie	Armed Ford	ces?	er in o.s.	IS. W	Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	0-		ck, White,		
urs at	<u>م</u>	-	4 Divorced	If Yes, Give Year or Dat	Ð		11	□Yes 2. ⊠ No	Specify:			Specif	y:	Black	
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permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Important: Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be risified at once.	Ì	20a. Method of Dis	sposition					ition (Name of atory or other place		Date			- City or T	own, State	
Page nent c nt: If			Cremation 3 5 ☐ Other (Spe	☐ Removal from Sicify)	tate			emetery	i	uary 8, 2010	Ни	ntinata	own N	MD	
permit. Departn Importa any inju		21. Signature of F	Funeral Service Lie	censee()			22.	Name and Addre	as of Facility	Sewell Fune		_		VI.D	
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hat the				s contributing to dea	ath but r	not resulting in	n the und	derlying cause giv	en in Part I.	23e. Dio	tobacco	o use con	tribute to	the cause of death?	
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v required been should	lete			-						24a. Wa	s an	24h	Were aut	opsy findings available	
he lav e has ige 2	Completed									- aut	opsy formed?		prior to o death?	ompletion of cause of	
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Attending Physician: r death. setor: After this certific by the funeral director, I	To Be	examiner? 1 ☐ Yes 2 2		Hospital: 1 ☐ In	patient	2 □ ER/Ou	utpatient	3 □ DOA Oth		Home 5 ⊠ Re		6 ∏Otl	ner (Spec	ify)	
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or Att after de Directe in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ed 28e. Place of building	of Injury g, etc. (- At home, fa (Specify)	ırm, stree	et, factory, office		28f. Location City or To			ber or Rui	ral Route Number,	
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)		Physician: To the bacaminer: On the ba and manner	sis of ex	xamination ar									
To the vithin To the comply	Me	29b Signature an	d title of certifier	11	_ \			29c. Licens	se number		29d. [Date signe	d (Month	, Day, Year)	
		· Ha	(b)	11/1	1)	DID	423		1	14	120	210	
	-	30. Name and add	dress of person wi	no completed cause	of deat	th (Item 23a)	(Type, P	rint)		, ~				m() 20678	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December ϋ009 Suzanne C. James 10:15 a^M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospice of Queen Anne's Queen Anne's Centreville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Min Director 83 NEW YORK 205-20-8639 NOV 1926 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 No MARYLAND QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 SOUTH COMMERCE STREET 21617 UNITED STATES Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4+ TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE THOMAS CARTIER ALINE STIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA BLUMGART/DAUGHTER 4109 31ST STREET, MOUNT RAINER, MARYLAND 20712 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State ANUARY 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Fellows, Helfer 408 S. Liberty Helfenbein & Newnam berty St. Centrevil Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause a each line. Immediate Cause (Final UROMUSCUAR Onset and Death Physician ENER disease or condition resulting in death) Medical Due to (or s consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown 2 No been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate performe death? Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Devil 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2/ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of o 29d. Date signed (Month, Day, Year) B Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 31. Date filed (Month, Day, Yea State egistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:35M)ec Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 1 X M 2 □ F Days Director May 12, 1943 MĎ 216-40-6368 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Prince Frederick MD Calvert 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20678 USA 4550 Dares Beach Road "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 9 Construction <u>Bricklayer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked ပ္ Robert Cooper Mildred Keemer 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Keemer - daughter-in-law 204 Tranquil Court, Prince Frederick, MD 20678 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Ernestine Jones Cemetery! January 2, 2010 Chesapeake Beach, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. any Gladi 1451 Dares Beach Rd., Prince Frederick, MD 20678 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? ģ Day Year Pregnant at time of death 2 No detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has performe Junson 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) funeral director, Be examiner? Other: 2 No 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending nours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No Accident
Suicide
Homicide Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. only one 29b. Signature MD

State Registrar 31. Date filed (Month, Day, Year)

KOCKUILL,

of person who completed cause of death (Item 23a) (Type, Print)

701 Randolph

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:15 P Steve W. Katcheves December 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's <u>Prince George's Hospital Center</u> Chever1v Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2□ F 69 Director 212-40-3545 4/20/1940 Greece Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a livalical Extrair or must be notified at 10c. City, Town or Location 1 □Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 108 W. Bay View Drive 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K1Yes 2 □ No IfYes, Give Year or Dates: 1962–64 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, It a Medical Exemina 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ሺ No Specify. White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vasilios Katcheves Athena Giftakis မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 W. Bay View Drive, Annapolis, MD 21403 <u>Styliani Katcheves/ Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Demetrios Cemetery 1/2/10 Annapolis, Maryland 21. Signature A Funcion Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ certificate has been si rector, page 2 should ! 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed of Vital 1 □Yes 2 No 5/2 or Attending Physiclan: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Kerk 28c. Injury at Work? Division 1 Natural 5 Pending Injury food bolus 1235M death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 1 ☐Yes 21 INO 3 Suicide ☐Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month/Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11154 31. Date filed (Month 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per HF G902 4/23/10 TT
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar				tificate of	Death		Reg. N	000	9	43	487	
	Physici	an	Decedent's Name (First, Midd		TO THE A DESIRER	The re	a common		2. Date of De Month Decemb	ath D	ay Ye	ar	3. Time of		
K.	/Media		4a. Facility Name (If not institution		F FRANKL			r Leagtion of Dooth			21, 200 c. County of D		6:30	PM	
)	Examir	er	Northhampton M		•		Frederic	r Location of Death	l	40	Freder				
Ī	Funeral Director		5. Social Security Number 217–28–5584		ge (In yrs. last bii			If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr. 1	av Year	Year) 1908 9. Birthplace (State or Foreign Country) Maryland				
	and w		Usual Residence of Decedent 10a. State 10b. County	v	10c. City, Tow	n or Loca	ation					100	d. Inside Cit	ty Limits	
	Maryla f sho	ō		•								100	1 DYes		
	r 28a-	Directo	Maryland Frede 10e. Street and Number	LICK	Frede	LTCK	10f. Zip Code			10g. C	itizen of What	t Countr	y?		
	h with		200 East Sixte	enth Street			21701				U.S.A.				
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No)-	14. Race - A Black, W				
9036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the "Accal Even" has the recitied at	by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 ☐ Yes 2½. If Yes Give	No		□Yes 2☐No		Though, Sto.y	ļ	Specify:		ite		
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12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		o nor use retired armer	1)			To see i	13.0			
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ılan	thould be filed wand Mental Hygie smarked other tumatic event, In	To B	John Henry Kli	-pp				Mary Ka	therine	Sch	ultz				
Baltimore, Maryland 21215-0036	ind 2 shou alth and N 27 is ma er trauma		19a. Informant's Name/Relations Mildred Eichel					and Number or Ru Blvd.,					Code)		
ore,	ges 1 and 2 it of Health If item 27 i or other tra		20a. Method of Disposition	2 D 2	20b. Place of cemeter	f Disposi ry, crema	tion (Name of atory or other place	e)	Date	20c. L	ocation - City	or Tow	n, State		
Ĕ	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S					rdens 12,	/28/09	Fre	derick	, M	arylar	nd	
Ball	permit. Page Department of Important: If any injury or once.	. 10	21. Signature of Funeral Service	Licensee	and the second second second second			ss of Facility DAILEY & MARKET						0.1	
П			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause t only one cause on each I	d the death. Do ine.	not enter	the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	diffic I CIK	1	Approximate Interval Betw	ween	
9	Physician		Immediate Cause (Final disease or condition	_a Ac	UTE MYC	CAR	DIAL IN	ERRCTION				(Onset and D کا کا کا		
1	/Medical Examiner		resulting in death)		a consequence										
		è	Sequentially list conditions, if any leading to immediate	b	a consequence	of):						-			
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Ď,	e exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence	of):		-				1			
09/89	ate be hysici he bu	Medical		d											
õ ×	# 50.00 H		IF FEMALE:												
n i	atter atter for u	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregnanc Other <i>(specify)</i>	y			23d. Date of Month		-	'ear	
	ss that gned b	by Pi	Part II. Other significant condition	ons contributing to death t	out not resulting in	the und	erlying cause give	en in Part I.	23e. Did t	obacco	use contribute	e to the	cause of de	eath?	
cords,	equire en siç ould b	edt	AL	ZHOLYERS DE	EMENTIA.	-			1 🗆 '	Yes 2	PMNo 3□] Probal	bly 4∏U	Inknown	
Hecc	The nospital of Attending Physician: The law requires that the of within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed									prior death	to com	sy findings a pletion of ca	available ause of	
VITAI V	ertifica ctor, I	Bec	25. Was case referred to medica examiner?	d				26. Place of Deat			0 12	163 2			
5	hysic this o		1 ∐ Yes 2 🖾 No		ent 2 ☐ ER/Ou			4 Escivuising no	ome 5 ☐ Resi	dence	6 ☐ Other (S	Specify)			
VISION	ending reath. or: After he funera	ation:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	igation	ury 28b. 1 ay, Year) li	Time of njury	28c. Injury Work M 1 🗆	yat t? Yes 2 □ No	28d. Describe	how inju	ry occurred				
בואו	tal or Att rs after de al Direct ed in by t	Certification: To	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place of In	jury - At home, fa tc. <i>(Specify)</i>	rm, stree	t, factory, office		28f. Location (City or To	Street a vn, Stat	nd Number or e)	r Rural i	Poute Numb	ber,	
	ne nospi in 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best Examiner: On the basis and manner	of examination an	e, death o	occurred at the tir stigation, in my o	ne, date and place pinion, death occur	and due to the red at the time,	cause(date an	s) and manne nd place, and	er as sta due to t	ited. he cause(s))	
į	North Con Con	Σ	29b. Signature and title of certifie	1	~~		29c. License				ate signed (M		ay, Year)		
			<u> </u>	1 VI	/ Y			2171		-	12/28/	09			
	3		30. Name and address of person	·			*			**	2.000				
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	Po Box rar's Signature	c '3 :	28 W	ALKERSVILL	E MD		21793				
	Registra	ar	DEC 2	8 2009 Jen	eur B.	1	arkel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 111-10cr s 2.3 PerPhys PGC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26 Pay Marilyn Killingham Dec. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Montgomery Silver Spring Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Year Director 306-34-1771 76 Tenn<u>essee</u> Aug. Usual Residence of Decedent show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director · 28a-f DC 1 X Yes 2 No Washington 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 20024 Funeral 700 7th Street SW United States or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Force: Black, White, etc. 1 Never Married 2 Married δ 2 X No within 72 hours after Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: African American "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, tite Mea Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Educator Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Elizabeth Snelling Alvin Thomas Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn E. Mosby/Niece 6613 Pointe E. Court Indianapolis, Indiana 46250 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) e Mem. Gardens 1/9/2010 | Largo, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. Riverdale Mem. Garden\$ 1/9/2010 21. Signature of Funeral Service License 4001 Benning Rd. NE Washington, DC 20019 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction **Medical** Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Fctopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 XNo Unknown the detached g Unknown as been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Overty Obesity Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 K No Yes 2X No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 13t No ၉ 1 Inpatient 2 KER/Outpatient 3 DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D19609 December 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JAN 0 5 2010

Tuli MD 10810 Darnestown Rd. Suite 202 Gaithersburg, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla	•	rtment of F		Mental Hy	_		9	1, 31, 9	ρΩ
			Registrar 1. Decedent's Name (First, Middle	Dealli	Reg. No. 2 U U 9 4 3 1					ath J				
	Physicia	an	Frances Stew		in				Month	Day	20	ear	9:00 a	М
	/Medic		4a. Facility Name (If not institution			· · · · · · · · · · · · · · · · · · ·	4h City Town	or Location of Dear			County of		3.00 a	
4	Examin	er	Hillhaven Nur	_		_	Adel						orge's	
Sec.		ř	5. Social Security Number	6. Sex	· ·	s. last birthday)	-	If Under 24 Hrs	8. Date of Bi				lace (State or For	reian
	Funeral Director		229-38-5241	1 □ M 21 F	78	Yrs.	Months Days	Hours Min		av. Year)	931	Cour	ginia	· ergii
			Usual Residence of Decedent		1 70				11.49				3	
	ylanc iow at		10a. State 10b. County		10c. 0	City, Town or Lo	cation					1	0d. Inside City Lir	mits
	Mar 1-f st iffed	ţ	Maryland Prin	ce George	e's		Hyattsv	ille					1 ☐ Yes 21 	JNo
	n 28%	Director	10e. Street and Number				10f. Zîp Code			10g. Cit	izen of Wh	at Cour	itry?	
	h wit		1900 Wooded	Court			2078	33		U	SA			
	deat	Funeral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Specify Yes or N	0-	14. Race -	Americ White,		
٥	after or ite		1 Never Married 2 Marr		2∏ No 3ive		i ∐Yes 2. TNo		no moun, do.,		Specify:			
5-0036	J within 72 hours after death with the Maryland jene. jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	3 Midowed 4 ☐ Divorced	Year or	Dates:			opeony:			Opecity.	****	<u> </u>	
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7	within iene. than " the Med	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)		oo nor use retire retary	d)			Law			
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Maryland 2	be find the	Be	George Stewar	*				l	beth Tur		ourname)			
Ĕ	d Me nark	은	19a. Informant's Name/Relations	oin (Time Brint)		10h Mailin	g Address (Street	and Number or F	Pural Pauta Num	har City	ar Town S	toto Zir	Cadal	
<u>a</u>	ages 1 and 2 should be filed vent of Health and Mental Hygiet; If Item 27 is marked other it y or other traumatic event, the		A. Stewart Lo			I .	Sawmill						Codej	
e,	1 and Healt em 2 ther		20a. Method of Disposition	1. C111/ 5011	20b	. Place of Dispo		Toda, II	Date		ocation - C		own State	
و	Pages nent of I ant: If Ite ary or o		1 Burial 2 Cremation		m State	cemetery, crer	natory or other pla	ce)	Jan 1,			•	,	
altimore,	rt. Part rtmer rtant njury		4 □ Donation 5 □ Other (S		Me		n Cremator			-			, Virgin	ia
g	permit. Pag Department Important: I any injury o)	21. Signature of Funeral Service	May	_	F.	rancis J 00 Unive	Scolling rsity Bl	s Funera vd. W.,	al Ho Silv	me In	c. rin	g, MD 20	901
г			23a. Part1. Enter the disease, or shock, or heart failure. List	complication that	t caused the de								Approximate Interval Between	
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ķ.	/Medical		disease or condition resulting in death)	a	o (or as a cons		TUMOL					-	6 months	,
	Examiner			Res	oirator	y Failu:	re						3 days	
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9/8 1	cate be executed oblysician and the burial-transit	dical		d. Core	onary H	eart Di	sease							
õ	certifica nding ph use as t	TO I	IF FEMALE:	1									- 10	
X Q Q	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant		outcome pf precedents		Ectopic pregnanc	y		(7)	23d. Date Mont		ery Day Year	. 1
	that the death ed by the atten detached for u	sici	in the past 12 months? 1 ☐ Yes 2 ☐No	4□Pre 9□Uni	gnant at time o	f death 5□	Other (specify) _				WOIII	11	Day rear	
л Э	w requires that the d been signed by the should be detached	Phy	9 Unknown			to: to at			00- Did	A=1		4 - 4		
	es th ignec	by	Part II. Other significant condition	_		-							he cause of death	
5	requires neen sign hould be	ted	Diabetes Melli	tus, Hype	erlipid	emia, Hy	pothyro:	idism,	S]Yes 2	□ No 3	L PIOI	ably 4 ੌ Unkn	IOWII
ပ္	a a c	adr.	Dysphagia							opsy	pri	or to ca	psy findings avail mpletion of cause	ilable e of
Vital Records,	ate ⊐	Completed							per 1□ Yes	formed? 2 🔀 No		ath? ∃Yes	2□ No	
<u> Ta</u>	clan: ertific ector,	Be (25. Was case referred to medical examiner?				1		eath (Check only	one)				
0	d is	2	1 ☐ Yes 2 ☑ No			☐ ER/Outpatien	· OLI DOX		Home 5 ☐ Res				ý)	
	ding Ph h. After th funeral	:uo	27. Manner of Death 1 X Natural 5 ☐ Pendin	g (Mo	te of Injury onth, Day Year)	28b. Time of Injury	Wo		28d. Describe	how inju	ry occurred	d		
IVISION	Attending r death. ector: After by the funer	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be]Yes 2□No	-					
₹	il or Attend after death I Director: , d in by the f	Certification:	4 Homicide determ	in ad ZOC. Fld	lding, etc. (Spe	cify)	eet, factory, office			own, State		or Hur	al Route Number,	1
_	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral C		29a, Certifier 1 Certifyir	g Physician: To t	he best of mv k	nowledge, deatl	n occurred at the t	ime, date and place	ce, and due to the	e causeís) and man	ner as s	tated.	
	24 hr 24 hr Fun etely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of exam	ination and/or in	vestigation, in my	opinion, death occ	curred at the time	e, date an	d place, ar	nd due t	o the cause(s)	
	To the within 2 To the complex	Ze	29b. Signature and title of certifie				29c. Licen:	se number		29d. Da	te signed	(Month,	Day, Year)	
1	0		· Natural	W				117843		Do	aamh -	~ ?	1, 2009	
	\sim		30. Name and address of person	who completed ca	use of death (It	em 23a) (Type		,0=0	}	De	noe	1 2	1, 2009	
			Vivek C. Vaid,				cace, B1	02, Hyat	tsville,	, MD	20782	2		
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Sig	inature								
	Registr		JAN 04	2010	audi ,	A. Ma	Kel							

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			For State Registrar	State of Maryl		rtment of F			iene _{eg. No.} 2009	43490
	Physici		1. Decedent's Name (First, Middle, Last)		UN A ANI E ENT			2. Date of Deat Month	h Day Year	3. Time of Death
100	/Medio		JAN 4a. Facility Name (If not institution, give s	E MAUD PLOV street and number)	<u>VMAN LEV</u>		Location of Death		/26/2009 4c, County of Dea	Z:00 P
أنهر	Lxumi	iĢi	5715 ROSS	NECK RD.			CAMBRIDG		DOR	CHESTER
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	0 Pir	thplace (State or Foreign
	Director	ŀ.	1/2-24-1684	lM 2 √ F	94 Yrs.	Morning Bayo	Tiodio Iviiii.	5/21/		SCOTLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	Mary First	ţo	MARYLAND DORCH	IECTED		(AMDDIDGI	D		1 □Yes 2 No
5	h the	Director	10e. Street and Number	LSTER		10f. Zip Code	CAMBRIDGI		0g. Citizen of What Co	ountry?
5	th wit		5715 ROS	S NECK RD.			21613		SCO	ΓLAND
ク	ems	Funeral		12. Was Decedent Ever i Armed Forces?	in U.S. 13. V	Vas Decedent of H		pecify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
36	or if	Y. F.	1 Never Married 2 Married	1 □Yes 2 No		□Yes 2No	Specify:	7110011, 0101,	Specify:	6, 616.
8	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be routhed at	Completed by	3 ♥ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		lent's Usual Occupa	ation		16b. Kind of Business	WHITE
21215-0036	nin 72 In "na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work done of NOT use retired	during most of work	ring	TOD. KING OF BUSINESS	midustry
	d with giene er tha	MO.	Liementary/Secondary (0-12)	College (1-4or 5+) 4		METEOI	ROLOGIST		ROYAL	AIR FORCE
nd	be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be rediffied at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Surname)	
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Maryland	S S S S		19a. Informant's Name/Relationship (Typ	,		,			, City or Town, State,	,
آ. آ	s 1 and 2 of Health item 27 I other tra		RICHARD MICHAEL PLOY 20a. Method of Disposition						BRIDGE, MD 2 20c. Location - City or	
<u></u>	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other place	i		,	,
	permit. Pages Department of Important: If ii any Injury or once.		21. Signatur Funeral Service License		7	EMATION CENT. Name and Address		27/2009	CAMBR	RIDGE, MD
ñ	Per any		M. Turran-	KMURL	1) cu	IRRAN-BROMV	VELL FUNERA	L HOME. P.A	308 HIGH ST. CA	MBRIDGE, MD 21613
			23a. Part . Enter the disease, or complice shock, or heart failure. List only on	ations that caused the decayse on each line						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	V.	levmor	ia				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a con	1					
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	uted i insit	Examine	Sequentially list conditions, if any, leading to immediate cause Full Industryin Cause (Disease or injury that initiated events	Due to (or as a con-	sequence or).					
'n.	an and rial-tra	Еха	resulting in death) Last	Due to (or as a con-	sequence of):					
8/60	cate be executed physician and the burial-transit	ical	d.							
		Medi	IF FEMALE:							
X P	death certifi e attending p d for use as	sician/Me	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	Fetal death 3 □	Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 □	Other (specify)			WOITH	Day (ear
ກຸ ກຸ	e law requires that the de has been signed by the le 2 should be detached	y Phy	Part II. Other significant conditions conf	ributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	requires that been signed b	ed by						1 ☐ Ye	s 2 No 3 P	robabiy 4 ☐ Unknown
ecord	aw re	Completed						24a. Was ar		utopsy findings available
r	sician: The law s certificate has b irector, page 2 sl	mo						autops perform	y prior to ned? death? 1 ☐ Yes	completion of cause of
VITAL	ertific ctor, I	Be C	25. Was case referred to medical examiner?				26. Place of Deat			2 1/21110
5	hysic this c	2	1 ☐ Yes 2 ☐ No		≥ ☐ ER/Outpatien	3 □ DOA Othe	er: 4 🗆 Nursing Ho	me 5 Reside	nce 6 ☐ Other (Spe	ecify)
ב כ	Attending Physician: It death. ector: After this certific by the funeral director.	ion	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year	r) 28b. Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury occurred	
VISION	death death ctor: y the	ficat	Accident investigation Suicide 6 Could not be	28e. Place of Injury - A	at home farm stre		res 2 □No	28f Location /St	reet and Number or R	um I Bouto Alumbos
3	al or A after I Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	or, ractory, omeo		City or Town	, State)	urar noute Number,
:	one hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exam	knowledge, death nination and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
;	lo the within fo the	Me	29b. Signature and title of certifler	and marrier stated.		29c. License	e number	29	9d. Date signed (Mon)	h, Day, Year)
)			> Current 1/6	in or		1/517	793	/	2/28/1	29
		t	30. Name and address of person who con	npleted cause of death (Item 23a) (Type, F	Print)	1-1	7	10.010	-(
		ĺ	31. Date filed (Month, Day, Year)	321 100	chester.	HUP, JUL	4/	ambri	dift MD	21613
	Stat Registra		DEC 29 20	32. Registrar's Si	griature .	ares				

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Amend AA Co.	#20c per . Health 1	Fu Dep	n.Dir 1/5/2010 Plea E. lo		Print in E f Marylan									ole.	
			For State Registrar	State 0	i iviai yiai		rtificate				-	Reg. N	2 U	09	43491
	Physici	212	1. Decedent's Name (First, Middle	e, Last)					-		2. Date of De		ay	Year	3. Time of Death
	/Medic		Loretta Jane La				T 41 - 611 - 1				Decemb	er	28,	2009	3:35 P ^M
	Examin	er	4a. Facility Name (If not institution Anne Arundel Me				Anna		Location	of Death			lc. County nne A		el
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.			-		r 24 Hrs.	8. Date of Bir	rth.			lace (State or Foreign
	Director		217-10-0917 Usual Residence of Decedent	1 LIM 2 LIF		89 Yrs.			1,04,0		Feb. 2	4,1	920	Mary	
	yland how at		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	Od. Inside City Limits
	ne Mar Ba-f sl	Director	Maryland Anne A	runde1	Ed	lgewate									1 □Yes 2 No
	with the la or 2 the no		10e. Street and Number	oda b Dodana			10f. Zip	.037				10g. C	Citizen of V	/hat Coun ISA	try?
	death ms 23	Funeral	500 Bay View Po	12. Was Dece	edent Ever in U	.S. 13.		_	ispanic O	ngin? (Spec	cify Yes or No Rican, etc.))-	14. Race	- Americ	
98	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 🔣 Marr	If Yes, Giv	2X No √e		1 ☐ Yes 2		an, mexica Specify		sican, etc.)			k, White, White	
ő	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Deceden		ates:	16a. Dece	dent's Usua	d Occup	ation			16b.	Kind of Bu		
21215-0036	hin 72 e. an "ne Medic	Completed	(Specify only higher	st grade completed) College (1	I-4or 5+)	life.	kind of wor DO NOT us	rk done d se retired	during mo i)	st of workin	g				,
213	led wit lygien her the		Elementary/Secondary (0-12)			Homer	naker	-	40 14-11		/Final Adjustite	1	ome	-1	
Maryland	d be fi	Be c	17. Father's Name (First, Middle,	Last)					Unkn		(First, Middle	, маю	en Surnam	e)	
ary	should be f and Mental H s marked ot umatic ever	T ₀	Robert Simons 19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address	(Street			Route Numb	er, City	or Town,	State, Zip	Code)
Σ	and 2 ealth a n 27 is		Terry L. Laws /	/ Son					ver I		Edgew				
altimore,			20a. Method of Disposition 1X Burial 2 ☐ Cremation		04-4-	Place of Dispo cemetery, cre Vetera	matorý or o	ther place	e)	1-5-2	O1O	Crow	Location INSVILL	City or To	wn, State Maryland
l‡i	t. Part rtant rtant		4 Donation 5 ☐ Sther (S		III										1 Home
Ba	Depar Impo any Ir		1/1/	dothe	6										D 21037
			25a. art1. Enter the disease, or shock or heart failure. List	complications that conly one cause on e	aused the deat	th. Do not en	ter the mod	e of dyin	ig, such a	s cardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Imme late Cause (Final disease or condition resulting in death)	_a Q-	Spira	+10	np	he	an	ion	ia				Onset and Death
	Examiner			Due to	(or as a consec):	*								
100	P #	ner	Sequentially list conditions, in all y, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Dive to	(or as a nonseo	pianna of):									
	executed n and ial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq	uence of):									
,092	e be e) sician buria			d	(0, 40 4 00, 100)	jachter oly									
92.00	rtificate ng phy as the	/ledi	IF FEMALE:												
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	tcome pf pregnation	aldeath 3	⊒Ectopic pr		,				23d. Dat	e of delive	ery Day Year
P.O.	at the de by the a	ysic	1 ☐ Yes 2 万 No 9 ☐ Unknown	9□Unkn	nant at time of o	jeath 5 (Other (sp	есіту)							
	uires that signed by d be deta	by Ph	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	ınderlying ca	ause giv	en in Part	1.	23e. Díd	tobacco	o use conti	ribute to th	ne cause of death?
ord	w require been sig										1 🗆	Yes	2 No	31 Prob	ably 4 □Unknown
Sec.	e law has b	Completed									24a. Was		. 1	Were auto prior to con death?	psy findings available npletion of cause of
<u>a</u>	sician: The law s certificate has t irector, page 2 s	e Col	25. Was case referred to medical						26 Plac	o of Dooth	1□ Yes	270		Yes	2 No
<u> </u>	Physicia this cert al directo	O B	examiner?		Inpatient 2	ER/Outpatie	nt 3 DO	Oth	OF:		ne 5□Res		6 □Oth	er (Specif	γ)
Division or Vital Records,	5 9 9	on: T	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date		28b. Time of Injury		8c. Injur Wor	y at k?	2	8d. Describe				
isio	or Attending after death. Director: After in by the fune	icati	2 Accident investig	not be	of injury - At h	ome, farm, st	M reet, factory		Yes 2	- 1	8f Location /	(Street	and Numb	er or Rura	l Route Number,
Ο̈́	ator A after I Direction by	Certification:	4 ☐ Homicide determ	buildi	ing, etc. (Specia	fy)		,		_	City or To			07 07 11010	Tribute rearriber,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fun			ng Physician: To the Examiner: On the b											
	thin 24 thin 24 the F	Medical	one) 29b. Signature and title of certifie	and man	ner stated.	1			e number						Day, Year)
	T W S		255. Olginaturo dilly title of Socialio	175) do	12		4	2/	7 11 2			-/-	/	
			30. Name and address of person	who completed caus	e of death (Iter	n 23a) (Type	Print)			11	. /	11-	111	10 -	ap. md.
\bigcirc	4			oldster	Menistrar's Sign	.D . /	16D=	re	nse	HW	1) 34	1.6	116	חריף	ali- a.
	Sta Registr		31. Date filed (Month, Day, Year)	4 2010	legistrar's Signa	B. 14	bark	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ LEWIS Month EN 2100 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANDRIN CHESAPEAKE HOSPICE HOUSE HARWOOD ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 Z F MARYLAND 577-28-4578 JANUARY 10, 1923 **Director** 86 Yrs. Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 WEST McKINSEY ROAD 21146 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married δ 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 73 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ FRANCIS SAVAGE LUCKETT HAZEL IRENE WALTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM R. LEWIS/SON 10803 SANTA CLARA DRIVE, FAIRFAX, VIRGINIA 22030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUARY 15 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MOUNT OLIVET CEMETERY 2010 WASHINGTON, D.C. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): ending physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? MANDA1 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence s after death.

I Director; After this d in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1. Natural injury work? 1 ☐ Yes 2 ☐ No House 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after

To the Funeral Dire

completed filled in b Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur Name and address of person who comp ause of death (Item 23a) (Type, Print) HIGH WAY ANN APOU, MOZIYO EYENSE ICHABI

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JAN 04

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER BRIAN JOSEPH LYNCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Ye 1 X M 2 - F Months Director Yrs 015-42-2258 58 June Usual Residence of Deceder or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Thurmont Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 219 Westview Drive 21788 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ò 1 Never Married 2 X Married Yes 2 K No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Sales Be 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic & Edward John Lynch Beatrice Hewitt 19a. Informant's Name/Relationship (Type, Print) Mary R. Lynch/ Wife <u> 219 Westview Drive, Thurmont, </u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 1/2/2010 21. Signature Funeral Service 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one choice on each line. Immediate Cause (Final Physician/ marring disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and I-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Records, Completed page 2 s certificate r: After this certifica e funeral director, r Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 🔲 Yes 2 💢 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Hospital or Attending injury work? 1 X Natural 5 Pending hours after death. Ineral Director: After dilled in by the fun Division 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier completed

Specify: White 16b. Kind of Business Industry <u>Auto Parts Recycling</u> 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21788 20c. Location - City or Town, State Rockville, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death embolism 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 MDD35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Hee Nam MD 400 West 7th Street, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature ORIGINAL.

3:00P

9. Birthplace (State or Foreign Country) New York

10d. Inside City Limits

1 X Yes 2 ☐ No

4c. County of Death

FREDERICK

<u>United States</u>

14. Race - American Indian, Black, White, etc.

State Registrar

To the F within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1,3494 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Margaret M. Lowe 1130A M December .20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges Lanham Doctors Community Hospital 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours Min. March Dy 1949 Washington DC Director 213-54-5704 60 Usual Residence of Decedent 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Glenn Dale Prince Georges Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20769 U.S.A. 10904 Prospect Hill Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ Page 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bernadine Rumbold George Lukasina Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code)
7011 Old Chaple Dr. Bowie, MD 20715 Raymond Lowe, Jr. (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State Beltsville, Maryland Chesapeake Crematory 1/5/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Md 20706 23a. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cronan disease or condition Medical resulting in death) Due to (or as a consequenc of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a sone-quaries of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 - NO 1 Yes Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 1 No Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 5 6 29d. Date signed (Month, Day, Year) MD D0062116 09 121 31

DHMH 17 Rev 7/2009

State Registrar MEKLIT

31. Date filed (Month, Day, Year)

OWE

7705

32. Registrar's Signature

Belle Point Drive, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WORKNEH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 28, Stephen Hull McNamara 2009 10:05 a M December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 1 1 X M 2 □ F Months Days Hours Min. Director 521-54-5424 66 April 12, 1943 New York Usual Residence of Decedent 10a. State 10b. County Show 10c. City. Town or Location 10d. Inside City Limits ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedest Event has a last by matters as Director 1 ☐ Yes 2 🖾 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 19165 Roman Way 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ⊠Yes 2 □ No IfYes, Give Year or Dates:Vietnam 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ I and 2 should be filed w Health and Mental Hygier om 27 Is marked other the Lawyer Food & Drug Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Francis McNamara ပ Maryde1 Hu11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Caroline McNamara / Spouse 19165 Roman Way; Gaithersburg, MD 20886 permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 1/5/2010 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funer Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Head and Neck Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician sthe burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) o 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 s autopsy certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 XNo director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}\boxtimes$ Other (Specify)HOSpice Hospital: 1 ∐Yes 2 🖾 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation To the Hospital or Attendir
) within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Loud 163748 9+ 12/29/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou 201 East University Parkway; Baltimore, MD 21218 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Emilia Mary Marle		S 1- For State Registrar	tate of Maryl		artment o			d Ment	tal Hy	_	Reg. No	200	9	43496
Physicia Medical Examin	n/	1. Decedent's Name (First, Mid				-				2. Date of De Month Decembe	eath			3. Time of Death 2238 hrs
	Ŭ.	Emilia Mary I	ion, give street and n	umber)				Location o	of Death	Decemb	4	c. County of	Death	
Formula		Calvert Memorial Ho. 5. Social Security Number	spital T6. Sex	7. Age (In yrs.	last highday)		ce Fred		r 24Hrs.	To Date of F		Calvert	O Dieth	nplace (State or
Funeral Director		159-56-6238	1 M 2 X F	51	Yrs	Mont			_	09/23			Foreign	
any	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Locat	tion								10d. Inside City Limits
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the Maryland a or 28a-f show tiffed at once.	Director	10e. Street and Number 521 Cathy Cou	rt	•			ip Code 20657					tizen of Wha ted St		
	/ Funeral	11. Marital Status 1 Never Married 2 1 3 Widowed 4 Di		2 No		es, spec	cify Cuban		c Origin? (Specify Yes or No- kican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white					
hours af	ed by	15. Decedent's Education (Sp	or Dates: ecify only highest gra	de completed)	16a. Deceder	nt's Usua	d Occupat				16b.	Kind of Busi		
36 thin 72 te. than "	Completed	Elementary/Secondary (0-12)) College (1-4 or 5+)	Nurse			20,1101	a o o o o o o		P	G Co	Go	vernment
5-00 lied wit Hygien I other		17. Father's Name (First, Middle	e, Last)		Harbe		ľ			(First, M iddle,	, Maider	Surname)	. 00	Veriment
2121 Ild be fi Mental narked event,	e Be	Emil Jacob Zs 19a. Informant's Name/Relation			19h Mailine	Addres	s (Street			l Jeanr ural Route Nu			State	Zin Codo)
MD 12 shorth and 1 27 is rumatic	-1				0.00					20657		only of Town,	, State, .	zip code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other ev		William H. Mar 20a. Method of Disposition 1 X Burial 2 Crematio		om State	Place of Dispos crematory or oth	her place	e) 1		31 2	Date		Location - C		
Iltim ii. Pag artment ortant:	-	4 Donation 5 Other S 21 Signature of Funeral Service		La	veille		etery	of Facility			1			10 110
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Physician Medical Examiner		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. <mark>Multiple Inj</mark>			ne mode	of dying,	such as ca	ardiac or	respiratory ar	rest, sh	ock, or hear	† 	Approximate Interval Between Onset and Death
		Sequentially list conditions,	b											
		if any, leading to immediate cause. Enter Underlying Cause (Discuss or injury that initiated	С	a consequence (
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OX 6876 ath certificate attending phy		IF FEMALE: (3b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 1 Live b	ant at time of d	2 Fe	tal death ner (Spe	_	Ectopic	pregnar	псу	23	d Date of d	elivery Da	y Year
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of Vital Records ing Physician: The law requi After this certificate has been funeral director, page 2 should	-ן כ									perfo 1 ✓ Yes	ormed?	de	ath? Yes	2 No
/ital	e n	25. Was case referred to medicate examiner? 1 ✓ Yes 2 No	Uponital	npatient 2 🗸	ER/Outpatient			of Death (0		Home 5	Reside	ence 6	Other:	
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Divisior ital or Attentura after death ral Director:	ertification:	3 Suicide 6 Cou	la not be		nome, farm, stree ad / Highway	t, factory	y, office bu	uilding, etc.		28f. Location (or Town, stoute 4 and	State)			Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ल्		hysician: To the besome of the basis of the	of examination a										
F 3 F 8	ž į	29b. Signature and title of certific			<u>.</u> .	29	c. License					Date signed	·	
	-	30. Name and address of person	who completed caus	se of death (Item	n 23a)		O.C.M	n.⊑. 			Dec	cember 2	7, 200	
tru 12		Margarita Korell MD.	Assistant Med	dical Examir	ner 111 Pe	enn St	reet, Ba	altimore,	MD 2	1201				
Stat Registra	te i	31. Date filed (Month Bex Yey)	9 2009 32. 8	gistrar's Signat	ure	e e la								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year ogan Sidner 5:00 pm 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Annapolis Medical Center Arundel Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** 1 MM 2□F Months Davs Hours Country) Director 11ana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City. Town or Location show 10d. Inside City Limits event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland 28a-f trundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Place 21114 1858 Sharwood United Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than " ar traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mackenzie 2 19a. Informant's Name/Relationship (Tipe Print)
Healthcare Provider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkway 2001 Medical Annapolis, Md Department of Health Important: If item 27 any injury or other troope. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 01/04/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis, MD 21401 64 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** day rotound disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Phystcian: The law requires that the death certificate be executed burial-transit Xtreme resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☑ Unknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 1 □ Yes 2 🗹 No 2 🗆 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 🖫 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 MP 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month,

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32. Registrar's Signature

lann-lann

2010

Year.

JAN 05

Anne Arundel Medical Center Annapolis,MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43498 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Thomas Morin December 30, 3009 200 4b. City, Town, or Location of Death 4c. County of Death Prince Boins C. cor 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 19 9. Birthplace (State or Foreign Country) MA ^{Year)} 1950 Months Days Hours Min. 265-82-4638 59 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1ÆYes 2 No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3311 Moylan Drive 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Practicing College (1-4or 5+) Elementary/Secondary (0-12) Economist Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Wilfred Joseph Morin Evelyn Odessa Nicoll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara McGuire Sister 3311 Moylan Dr. Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/1/2010 Glen Burnie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility obert E. Evans Funeral Home d, Bowie, Md. 20715

Physician /Medical Examiner

Physician

/Medical Examiner

Director

Funeral

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Completed

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Modifical Examples that must be notified at appear.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burital-transit Medical Certification: To Be Completed by cate has t page 2 s

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SALVADOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

shock, or heart failure. List only or	ne cause on each line.	Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Athenselectic Cardner 25 Cm	an Heart Disease Onset and Death
Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of):	
	J	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)
1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	dome 5 Residence 6 Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my knowledge, death occurred at the time, date and place ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State FCHD Registraramend #7per FH, 12/29/09. LECertificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 26 Year 2009 John Mills 1:39 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) ine 2,1947 1**X** M 2 □ Director Washington, DC 219-46-6297 61 62 Yrs. June Usual Residence of Decedent 28a-f show 10a, State 10b. Count 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Frederick Maryland New Market 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6528 North Shore Way 21774 United States or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian the Medical Examiner Black White etc. 2 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Datesunknown 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking/Financial Advisor Banking/Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Department of Health and Ment. Important: If item 27 is marked any injury or car. be Mills Benjamin Dorothy Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela W. Mills / Wife 6528 North Shore Way/ New Market, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 12/29/2009 Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike/Frederick, Maryland 21702 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Athers schools cardio ves cular disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: ISe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Pregnant at time of death Month Dav Year Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s Jas performed 2 🗌 No 1 Yes director, 25. Was case referred to med Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner o Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred atural 5 Pending injury 2 Accident Investigation 6 Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3altimore, Maryland 21215-0036 Box 68760 P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05206 Medical Docto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Frederick VILL ands 54 400 4 3 21701 31. Date filed (Month Pay Year) 32. Redistrar's Signature State 9 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Helen Hughey Moffett Medical 16 2009 5:15a December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick College View Nursing Home Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) ct. 3, 1929 1 □ M 2 😾 F Months Days Hours Min South Carolina Director 249-48-0859 80 Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 2457 Five Shillings Road 21701 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Lord & Taylor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabel Goodall <u>Henry Hughey</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Edward C. Moffett/ Husband other <u> 2457 Five Shillings Road, Frederick, Maryland 21701</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 12/21/2009 Frederick, Maryland 21. Signature uneral Service Lice 22. Name and Address of Facility Stauffer Funeral Homes P. A. Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final ∲nysician/ OBSTRUCTIVE CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of burial-transit Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical If or Attending Physician: The law requires that the death certificate be after death.
Infectors After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the burners. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSONS DIJEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work's Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined the Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 121936

State Registrar THIMAS JOHNSON DR

Registrar's Signature

FREDERICE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65C

A. DONELSON

31. Date filed (Month, Day, Year)